Local Government
OMBUDSMAN

Parliamentary
and Health Service
Ombudsman

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

Part two: the complaint made by Mr Allan Cannon and Mrs Anne Handley

HC 203-II

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Section 1: introduction and summary

1 This is the final report of our joint investigation into complaints made by Mr Cannon's parents against: the London Borough of Havering (the Council); Barking, Havering and Redbridge Hospitals NHS Trust (the Trust); the New Medical Centre, Romford (the Practice); and the Healthcare Commission. The report contains our findings, conclusions and recommendations with regard to their areas of concern.

The complaint

2 Mr Cannon was a 30 year old man with severe learning disabilities. He also suffered from epilepsy which was difficult to control. He had very little speech but was able to communicate with his family and he was particularly close to his sister, Jane. He was able to walk unaided but often needed support when he was feeling unsteady on his feet. Mr Cannon was smiling and *'mischievous'* with a fine sense of humour. He enjoyed participating in activities, social events and outings with his family and carers, but he also liked lazing around and relaxing in an easy chair or bean bag.

3 At the time of the events complained about, Mr Cannon lived at home with his mother, stepfather and sister. He attended a day centre five days a week with occasional stays at the Grange, a Council owned care home.

4 In June 2003 Mr Cannon was at the Grange while his mother was on holiday. At some point during the night of 26/27 June 2003, in circumstances which remain unclear, he fractured his upper femur (the thigh bone) and was admitted to the Trust on 27 June 2003. After surgery to repair the fracture Mr Cannon was discharged to his mother's home on 4 July 2003.

5 Mr Cannon was unwell after he was discharged. He was in pain and not sleeping, and it was difficult to persuade him to eat or drink. On 8 July 2003 he was seen by his GP who arranged for him to be readmitted to the Trust. He was discharged to his mother's home on 14 July 2003.

6 On 6 August 2003 Mr Cannon was seen at home by his GP who diagnosed an infection and prescribed antibiotics. Over the next few days his condition deteriorated, he suffered many seizures and developed a high temperature.

7 On 10 August 2003 Mr Cannon was taken to the Accident and Emergency Department (A&E) at the Trust with dehydration, malnutrition and renal failure. He was admitted to the Receiving Room (a medical admission ward), but his condition did not improve and on 11 August 2003 he was transferred to the Intensive Therapy Unit (ITU). His condition stabilised and on 13 August 2003 he was moved to the High Dependency Unit (HDU). There his condition deteriorated and he suffered a cardiac arrest. He was resuscitated and transferred back to the ITU. However, after discussion with his family, it was agreed that there was no hope of recovery and treatment was withdrawn. Mr Cannon died on 29 August 2003.

8 The Coroner asked the police to investigate the circumstances of Mr Cannon's injury at the Grange. Two pathologists carried out separate post mortems and both concluded it was likely that Mr Cannon's fracture was caused by a fall and that his death was a result of bronchopneumonia. An inquest was held and the Coroner recorded a verdict of accidental death.

9 Mr Cannon's parents said they were appalled by what happened to their son. At one point in the complaints process they said:

'All of Mark's 30 years had been a struggle for equal rights to health care, support and services within the society he lived. We battled continuously with virtually no progress.'

10 Mr Cannon's parents have given permission for Mencap to act as their representative.

The overarching complaint

11 Mr Cannon's parents believe their son's death was avoidable and he received less favourable treatment for reasons related to his learning disabilities. We have called this aspect of the complaint 'the overarching complaint'.

Complaint against the Council

12 Mr Cannon's parents complain that:

Complaint (a): their son was provided with inadequate care by the Council and this led to his injury and, ultimately, his death. They believe the Council failed in its duty to keep their son safe while he was in its care as a result of poor care planning, poor supervision, weak management and inadequate staffing, including training and induction. They also believe the Council repeatedly failed to properly investigate the circumstances of their son's injury or to take any responsibility for the part its failings played in his injury and subsequent death.

Complaint against the Trust

13 Mr Cannon's parents complain that:

Complaint (b): during each of his admissions, the Trust failed to provide their son with adequate care and treatment or to properly plan his discharge and aftercare. They believe these failures led to the decline in Mr Cannon's health and his death.

Complaint (c): the Trust has failed to investigate the family's complaint about their son's care properly or to apologise for the many shortcomings which they believe occurred.

Complaint against the Practice

14 Mr Cannon's parents complain that:

Complaint (d): the GP Practice failed to provide their son with adequate care and that more could have been done to diagnose the reasons for the deterioration in his condition following his discharge from hospital. They believe that if the Practice had taken action sooner their son might have received the care he needed and might not have died.

Complaint against the Healthcare Commission

15 Mr Cannon's parents complain about:

Complaint (e): the way the Healthcare Commission handled their complaint. They say the Healthcare Commission failed to properly investigate their complaints against the Trust or take appropriate action where they identified serious shortcomings. They also say the Healthcare Commission's review took too long.

16 Mr Cannon's parents believe they have not had answers to all their questions and they hope the Ombudsmen's investigation will provide them with those answers. They hope other people will not go through the same experiences as their family.

The Ombudsmen's remit, jurisdiction and powers

General remit of the Health Service Ombudsman

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

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

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

20 When considering complaints against GPs, she may look at whether a complainant has suffered injustice or hardship in consequence of action taken by the GP in connection with the services the GP has undertaken with the NHS to provide. Again, such action may have been taken by the GP himself or herself, by someone employed by or acting on behalf of the GP or by a person to whom the GP has delegated any functions.

21 The Health Service Ombudsman may carry out an investigation in any manner which, to her, seems appropriate in the circumstances of the case and in particular may make such enquiries and obtain such information from such persons as she thinks fit.

22 If the Health Service Ombudsman finds that service failure or maladministration has resulted in an injustice, she will uphold the complaint. If the resulting injustice is unremedied, in line with her *Principles for Remedy*, she may recommend redress to remedy any injustice she has found.

Remit over the Healthcare Commission

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

Health Service Ombudsman – premature complaints

24 Section 4(5) of the *Health Service Commissioners Act 1993* states that the Ombudsman generally may not investigate any complaint until the NHS complaints procedure has been invoked and exhausted, and this is the approach she takes in the majority of NHS complaints made to her.

25 However, section 4(5) makes it clear that if, in the particular circumstances of any case, the Health Service Ombudsman considers it is not reasonable to expect the complainant to have followed the NHS route, she may accept the case for investigation notwithstanding that the complaint has not been dealt with under the NHS complaints procedure. This is a matter for the Health Service Ombudsman's discretion after proper consideration of the facts of each case.

26 In this instance, Mr Cannon's parents had not previously complained to the Practice. However, in their complaint to the Health Service Ombudsman they make clear their concern that the Practice had failed to provide adequate care and treatment to their son when he was cared for at home by his mother after his injury at the Grange. They say they had become exhausted by the complaints process and had felt unable to pursue this matter previously. However, they consider there were shortcomings in the care provided by the Practice and they say that if these are not explained and examined they would still not fully understand what had happened to their son. Taking these matters into account, the Health Service Ombudsman exercised her discretion to investigate the complaint against the Practice under the provisions of the Act which governs her work.

General remit of the Local Government Ombudsman

27 Under the *Local Government Act 1974 Part III*, the Local Government Ombudsman has wide discretion to investigate complaints of injustice arising from maladministration by local authorities (local councils) and certain other public bodies. He may investigate complaints about most council matters, including Social Services and the provision of social care.

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

Powers to investigate and report jointly

29 *The Regulatory Reform (Collaboration etc. between Ombudsmen) Order 2007* clarified the powers of the Health Service Ombudsman and the Local Government Ombudsman, with the consent of the complainant, to share information, carry out joint investigations and produce joint reports in respect of complaints which fell within the remit of both Ombudsmen.

30 In this case, the Health Service Ombudsman and the Local Government Ombudsman agreed to work together because the health and social care issues were so closely linked. A co-ordinated response consisting of a joint investigation leading to the production of a joint conclusion and proposed remedy in one report seemed the most appropriate way forward.

The investigation

31 During the investigation, our investigator met Mr Cannon's parents and their representatives to ensure that we had a full understanding of their complaint. Mr Cannon's health records, the Trust's complaint file and legal file relating to the Coroner's inquest, the Healthcare Commission's file and the Council's complaint file were examined. Mr Cannon's family also submitted papers setting out their complaint. Papers were also obtained from HM Coroner for the Eastern District of Greater London including her summing up and verdict. Interviews were conducted with the Council's Learning Disabilities Service Manager and with the Council's Complaints Manager at the time of the events complained about. All of the bodies under investigation also provided additional information in response to our specific enquiries.

32 We obtained specialist advice from a number of professional advisers (the Professional Advisers):

- Ms L Etherington, a nurse specialising in A&E nursing (the A&E Nursing Adviser).
- Dr T Malpass, a consultant physician specialising in A&E Medicine (the A&E Medical Adviser).
- Mr J Albert, an orthopaedic surgeon (the Orthopaedic Surgical Adviser).
- Dr J Skoyles, a consultant anaesthetist with expertise in medical care in high dependency and intensive care settings (the Anaesthetic Adviser).
- Mr B Lucas, a nurse specialising in the care of patients in an orthopaedic setting (the Orthopaedic Nursing Adviser).
- Ms E Onslow, a nurse with expertise relating to discharge planning and community nursing (the Community Nursing Adviser).
- Ms A Kent, a nurse with expertise relating to the care of patients with learning disabilities (the Learning Disability Nursing Adviser).
- Dr J Rasmussen, a general practitioner (the GP Adviser).

In addition, Dr T Owen (a general practitioner) and Mrs S Lowson (an experienced acute nurse and a Lead Clinician at the Office of the Health Service Ombudsman) provided further professional advice in respect of the complainants' response to the draft report.

33 The Professional Advisers are specialists in their field and in their roles as advisers to the Ombudsmen they are completely independent of any NHS body, local government body and the Healthcare Commission. Their role is to help the Ombudsmen and their investigative staff understand the clinical aspects of the complaint.

34 In this report we have not referred to all the information examined in the course of our investigation, but we are satisfied that nothing significant to the complaint or our findings has been overlooked.

Our decisions

35 Having considered all the available evidence related to Mr Cannon's parents' complaint, including their recollections and views and their response to our draft report, and taken account of the clinical advice we have received, we have reached the following decisions.

Complaint against the Council

36 The Local Government Ombudsman finds that the Council failed to provide and/or secure an acceptable standard of care for Mr Cannon and that, as a result, his safety was put at risk. That failure constitutes **maladministration** by the Council. The accident suffered by Mr Cannon might well have been avoided if the failures identified in the report had not occurred. The Local Government Ombudsman also finds that the Council did not respond to the complaint made by Mr Cannon's parents in an appropriate way and that this caused further distress to his family. That, too, was **maladministration**. The maladministration found by the Local Government Ombudsman caused **injustice** to Mr Cannon's parents.

Complaint against the Trust

37 The Health Service Ombudsman finds that the Trust failed to provide Mr Cannon with a reasonable standard of care and treatment. In particular, pain management, post-operative monitoring, discharge arrangements and nursing care were inadequate. This was **service failure** which was in many respects for disability related reasons. She also concludes that the Trust's acts and omissions constituted a failure to live up to human rights principles of dignity, equality and autonomy. The failures on the part of the Trust added to Mr Cannon's suffering and lessened his chances of recovery. The Trust's complaint handling was also poor. This **maladministration** compounded the **injustice** and caused further distress to Mr Cannon's family. The Health Service Ombudsman **upholds** the complaint against the Trust.

Complaint against the Practice

38 The Health Service Ombudsman finds the service provided to Mr Cannon after he was discharged from hospital on 14 July 2003 did not fall significantly below a reasonable standard in the circumstances. She considers the failings identified **did not amount to service failure**. The Health Service Ombudsman **does not uphold** the complaint against the Practice.

Complaint against the Healthcare Commission

39 The Health Service Ombudsman finds **maladministration** in the way the Healthcare Commission reviewed Mr Cannon's parents' complaint against the Trust. This led to **injustice** because they did not receive the robust review of their complaint to which they were entitled. The Health Service Ombudsman **upholds** the complaint against the Healthcare Commission.

The overarching complaint

40 We conclude that maladministration by the Council and service failure by the Trust meant Mr Cannon was treated less favourably for reasons related to his learning disability. Furthermore, the acts and omissions of the Council and the Trust constitute a failure to live up to human rights principles of dignity, equality and autonomy.

41 We also conclude that Mr Cannon's death occurred in consequence of the maladministration and service failure which we identified and, therefore, that his death was avoidable.

42 In this report we explain the detailed reasons for our decision and comment on the particular areas where Mr Cannon's parents have expressed concern to the Ombudsmen.

Section 2: the basis for our determination of the complaints

Introduction

43 In simple terms, when determining complaints that injustice or hardship has been sustained in consequence of service failure and/or maladministration, the Ombudsmen generally begin by comparing what actually happened with what should have happened.

44 So, in addition to establishing the facts that are relevant to the complaint, we also need to establish a clear understanding of the standards, both of general application and which are specific to the circumstances of the case, which applied at the time the events complained about occurred, and which governed the exercise of the administrative and clinical functions of those bodies and individuals whose actions are the subject of the complaint. We call this establishing the overall standard.

45 The overall standard has two components: the general standard which is derived from general principles of good administration and, where applicable, of public law; and the specific standards which are derived from the legal, policy and administrative framework and the professional standards relevant to the events in question.

46 Having established the overall standard we then assess the facts in accordance with the standard. Specifically, we assess whether or not an act or omission on the part of the body or individual complained about constitutes a departure from the applicable standard. If so, we then assess whether, in all the circumstances, that act or omission falls so far short of the applicable standard as to constitute service failure or maladministration.

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

The general standard

Principles of Good Administration

48 Since it was established the Office of the Parliamentary and Health Service Ombudsman has developed and applied certain principles of good administration in determining complaints of service failure and maladministration. In March 2007 the Parliamentary and Health Service Ombudsman published these established principles in codified form in a document entitled *Principles of Good Administration*.

49 The document organises the established principles of good administration into six Principles. These Principles are:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right, and
- Seeking continuous improvement.

50 We have taken all of these Principles into account in our consideration of Mr Cannon's parents' complaints and therefore set out below in greater detail what the *Principles of Good Administration* says under these headings:[1]

[1] *Principles of Good Administration* is available at www.ombudsman.org.uk

'Getting it right' means:

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

'Being customer focused' means:

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

'Being open and accountable' means:

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating criteria for decision making and giving reasons for decisions.
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for actions.

'Acting fairly and proportionately' means:

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

'Putting things right' means:

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

'*Seeking continuous improvement*' means:

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

Principles for Remedy

51 In October 2007 the Parliamentary and Health Service Ombudsman published a document entitled *Principles for Remedy*.[2]

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

53 We have taken the *Principles for Remedy* into account in our consideration of Mr Cannon's parents' complaints.

The specific standard

Disability discrimination

Legal framework

Disability Discrimination Act 1995

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

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

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

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

[2] *Principles for Remedy* is available at www.ombudsman.org.uk

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

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

Policy aims

59 The *Disability Discrimination Act 1995* recognises that the disabling effect of physical and mental impairment will depend upon how far the physical and social environment creates obstacles to disabled people's enjoyment of the same goods, services and facilities as the rest of the public.

60 The key policy aim behind the legislation is to ensure that as far as reasonably possible disabled people enjoy access not just to the same services, but to the same standard of service, as other members of the public. In other words, those who provide services to the public, whether in a private or public capacity, are to do whatever they reasonably can to eradicate any disadvantage that exists for a reason related to a person's physical or mental impairment.

61 The critical component of disability rights policy is therefore the obligation to make *'reasonable adjustments'*, which shapes the *'positive accent'* of the *Disability Discrimination Act 1995*. This obligation recognises that very often equality for disabled people requires not the same treatment as everyone else but different treatment. The House of Lords made explicit what this means in a case (*Archibald v Fife Council*, [2004] UKHL 32, judgment of Baroness Hale), which although arising from the *Part 2* employment provisions of the *Disability Discrimination Act 1995*, has bearing on the *Part 3* service provisions also:

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

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

Policy and administrative guidance

Disability Rights Commission Codes of Practice

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

64 Before the establishment of the Disability Rights Commission in April 2000, the relevant Secretary of State, on the advice of the National Disability Council, published a statutory code of practice on the duties of service providers under

Part 3 of the *Disability Discrimination Act 1995* entitled *Code of Practice: Goods, Facilities, Services and Premises* (1999), itself a revision of an earlier code of practice published in 1996.

65 On its establishment in 2000 the Disability Rights Commission consulted on a further revised code of practice, which came into force on 27 May 2002 as the *Disability Discrimination Code of Practice (Goods, Facilities, Services and Premises)*. The revised code of practice not only updated the previous codes but anticipated the changes to the law that were due to come into effect in 2004, in particular with respect to the duty to remove obstructive physical features.

66 The 2002 code made it clear that a service provider's duty to make reasonable adjustments is a duty owed to disabled people at large and that the duty is *'anticipatory'*:

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

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

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

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

68 In 2001 the Department of Health published a White Paper, explicitly shaped by the relevant legislation (including the *Disability Discrimination Act 1995* and the *Human Rights Act 1998*), with a foreword written by the then Prime Minister, outlining the Government's future strategy and objectives for achieving improvements in the lives of people with learning disabilities.

69 The White Paper identified four key principles that it wanted to promote: legal and civil rights (including rights to education, to vote, to have a family and to express opinions); independence; choice; and inclusion (in the sense of being part of mainstream society and being integrated into the local community).

70 As the White Paper explained, the intention was that *'All public services will treat people with learning disabilities as individuals, with respect for their dignity'*.

71 The fifth stated objective of the Government was to *'enable people with learning disabilities to access health services designed around individual needs, with fast and convenient care delivered to a consistently high standard, and with additional support where necessary'*.

72 The Department of Health also published in 2001 two circulars aimed jointly at the health service and local authorities, focusing on the implementation of Valuing People and including detailed arrangements for the establishment

of Learning Disability Partnership Boards: *HSC 2001/016* and *LAC (2001) 23*.

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

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

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

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

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

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

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

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

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

In practice

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

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

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

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

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

Human rights

Legal framework

Human Rights Act 1998

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

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

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

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

Policy aims

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

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

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

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

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

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

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

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

In practice

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

91 Failure to meet this standard will not only mean that the individual has been denied the full enjoyment of his or her rights; it will also mean that there has been maladministration or service failure.

92 To be confident that it has met the requisite standard, a public authority will need to show that it has taken account of relevant human rights principles not only in its design of services but in their implementation. It will, for example, need to show that it has made decisions that are fair (including by giving those affected by decisions a chance to have their say, by avoiding blanket policies, by acting proportionately and by giving clear reasons); that it has treated everyone with respect (including by avoiding unnecessary embarrassment or humiliation, by enabling individuals to make their own choices so far as practicable, and by having due regard to the individual's enjoyment of physical and mental wellbeing); that it has made genuine efforts to achieve equality (including by avoiding unjustifiable discrimination, by taking reasonable steps to enable a person to enjoy participation in the processes that affect them, by enabling a person to express their own personal identity and by actively recognising and responding appropriately to difference); that it has preserved human dignity (including by taking reasonable steps to protect a person's life and wellbeing, by avoiding treatment that causes unnecessary mental or physical harm, and by avoiding treatment that is humiliating or undignified); and that it has promoted individual autonomy (including by taking reasonable steps to ensure that a person can live independently).

93 It is not for the Ombudsmen to make findings of law. It is, however, the role of the Ombudsmen to uphold the published *Principles of Good Administration*. These include the obligation to 'get it right' by acting in accordance with the law and with regard for the rights of those concerned. Where evidence of compliance is lacking, the Ombudsmen will be mindful of that in determining the overall quality of administration and service provided in the particular case. In cases involving health and social care, such considerations are so integral to the assessment of good administration and good service delivery that it is impossible to ignore them.

Health and social care

Legal framework

National Health Service Act 1977

94 The *National Health Service Act 1977* made it a duty for the NHS to promote services to improve health. Section 1 of the Act confers a duty on the Secretary of State to secure improvements in the physical and mental health of the population. Section 22 creates a duty of co-operation between NHS bodies and local authorities in exercising their respective functions.

National Health Service and Community Care Act 1990

95 The *National Health Service and Community Care Act 1990* clarified that local authorities have a duty to assess the individual community care needs of any person who, in their view, requires services and then have to decide what services should be provided. The Act also required health authorities to assist in the assessment of need in cases where the person appeared to require the services of the NHS.

National Assistance Act 1948

96 Section 21(1) of the *National Assistance Act 1948*, as originally enacted, placed a duty on a local authority to provide residential accommodation for persons aged 18 and over who are ordinarily resident in the council's area and who are, by reason of age, infirmity or other circumstances, in need of care and attention not otherwise available to them. Subsequent amendments replaced that duty with a power save to the extent that the Secretary of State directs that the arrangements must be made. In paragraph 2(1)(b) of Appendix 1 of Department of Health Circular *LAC (93)10* the Secretary of State has directed local authorities to make arrangements under section 21(1) of the 1948 Act. Paragraph 4 of Appendix 1 to the Circular directs local authorities to make arrangements under section 21(1) of the 1948 Act for a number of purposes, including:

> *'(c) to enable persons for whom accommodation is provided to obtain –*
>
> *1. medical attention*
>
> *2. nursing attention … and*
>
> *(e) to review regularly the provision made under the arrangements and to make such improvements as the authority considers necessary.'*

97 By section 26(1) of the 1948 Act, arrangements made by a local authority under section 21 of that Act may include arrangements made with a voluntary organisation where that organisation manages premises which provide for reward residential accommodation and the arrangements are for the provision of such accommodation within those premises.

Care Standards Act 2000

98 The main purpose of the *Care Standards Act 2000* was to reform the regulatory system for care services in England and Wales. For the first time, local authorities were to be required to meet the same standards as independent sector providers. In England the Act provided for an independent National Care Standards Commission, replaced by the Commission for Social Care Inspection in April 2004, to undertake a regulatory function to ensure that standards were met.

Care Homes Regulations, amended 2003, incorporating National Minimum Standards for Social Care

99 These Regulations and standards form the basis of the regulatory framework established under the *Care Standards Act 2000* for the conduct of care homes and were drafted following consultation with service users, providers and regulators. The Regulations contain a statement of national minimum standards published by the Secretary of State under section 23(1) of the *Care Standards Act 2000* applicable to care homes (as defined by section 3 of that Act) which provide accommodation, together with nursing or personal care, for adults (aged 18 to 65). The standards for care homes for adults state:

> *'2.1 New service users are admitted only on the basis of a full assessment undertaken by people competent to do so, involving the prospective service user, using an appropriate communication method and with an independent advocate as appropriate.*
>
> *'2.2 For individuals referred through Care Management, the registered manager obtains a summary of the single Care Management (health and social services)*

assessment – integrated with the Care Programme Approach (CPA) for people with mental health problems – and a copy of the single Care Plan.

'2.4 The home develops with each prospective service user an individual Service User Plan based on the Care Management Assessment and Care Plan or the home's own needs assessment.

'3.2 All specialised services offered (e.g. services for people with mental health problems, sensory impairment, physical disabilities, learning disabilities, substance misuse problems, transition services, intermediate or respite care) are demonstrably based on current good practice, and reflect relevant specialist and clinical guidance.

'3.3 Staff individually and collectively have the skills and experience to deliver the services and care which the home offers to provide.

'3.10 In homes providing planned respite, the statement of purpose, assessment process and individual Service User Plan are designed to meet the specific needs of the people for whom the service is intended.

'6.2 The Plan is generated from the single Care Management Assessment/Care Plan or the home's own assessment, and covers all aspects of personal and social support and healthcare needs as set out in Standard 2.

'6.3 The Plan sets out how current and anticipated specialist requirements will be met (for example through positive planned interventions; rehabilitation and therapeutic programmes; structured environments; development of language and communication; adaptations and equipment; one-to-one communication support).

'6.5 The Plan is drawn up with the involvement of the service user together with family, friends and/or advocate as appropriate, and relevant agencies/specialists.

'9.2 Risk is assessed prior to admission according to health and social services protocols and in discussion with the service user and relevant specialists; and risk management strategies are agreed, recorded in the individual Plan, and reviewed.

'9.3 Action is taken to minimize identified risks and hazards, and service users are given training about their personal safety, to avoid limiting the service user's preferred activity or choice.'

Community Care (Delayed Discharges etc) Act 2003

100 The *Community Care (Delayed Discharges etc) Act 2003* placed a duty upon local authorities to enable timely, well planned discharges from hospital for people who had a need for social care. It required the NHS to alert social services departments to patients who may need social care support to enable discharge from hospital.

Policy aims

101 During the 1990s the Government recognised that the arrangements made by the NHS and local authorities for assessment, care planning, care co-ordination and review for people with complex needs were often inadequate. Failures

to anticipate care needs or to act on care plans meant that people with complex health and social care needs experienced disjointed care and did not know what to do in a crisis or when their situation was changing. Sometimes this led to inappropriate admission to hospital, premature placement in long-term residential or nursing care, or inadequate arrangement for discharge from hospital.

102 To address these difficulties, the roles of the NHS and local authorities with respect to assessment, care planning and care co-ordination were clarified in the *National Health Services and Community Care Act 1999*. Valuing People described how assessment, care planning and care co-ordination should apply to people with learning disabilities. Together these documents say that for people with multidisciplinary and/or multi-agency care needs, including people with learning disabilities:

- There was to be a *'needs-led'* system of care management, based on an assessment of the service user's needs and circumstances. Assessment was a service in its own right and led by social services. The NHS was to co-ordinate with social services if a health needs assessment was also required.

- Once an individual's needs had been assessed, the service to be provided or arranged and the objectives for any intervention were to be agreed in the form of a care plan, including healthcare interventions. For people with learning disabilities, care plans were to address communications needs.

- Service users' views were to be taken into account and carers were to be appropriately involved.

- Carers were to be offered an assessment of needs in their own right to which local authorities should respond. The NHS was also to consider ways of supporting carers.

- Where people had complex needs, there was to be someone with responsibility for co-ordinating care and for people with learning disabilities who made long-term use of public services, care co-ordination was to be available by 2002.

- Care needs were to be reviewed regularly, and by someone not involved in direct service provision.

- NHS trusts, primary care providers and local authorities were to have arrangements in place to identify people who had additional health, social or other needs that needed to be met before they left hospital and were to provide them with a named person to co-ordinate all stages of their journey through hospital and back to the community.

Policy and administrative guidance

HSC 2001/016 and *LAC (2001) 23: Valuing People: A New Strategy for Learning Disability for the 21st Century:* implementation

103 Valuing People drew on the legislation and guidance described above and clarified how it was to be applied to people with learning disabilities. *HSC 2001/016* and *LAC (2001) 23* circulars laid out specifically what was expected of the NHS and local authorities. Local authorities would, by October 2001, have established Learning Disability Partnership Boards that would develop integrated plans and services for people with learning disabilities, taking account of the health needs of the population, resources and service users and

carers' views. Councils were expected to take the lead role with the Learning Disability Partnership Boards for ensuring appropriate plans were drawn up and provision was made for people with learning disabilities to whom councils had a duty of care.

104 By winter 2002 people with learning disabilities who made substantial and long-term use of publicly funded services were to have a named person to act as their service co-ordinator. This person was to pay particular attention to achieving effective organisation and monitoring of services provided by all agencies. A health facilitator was to be available to help people to access the healthcare they needed and to help healthcare providers develop appropriate skills – especially in primary and secondary care.

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

- Food and nutrition
- Personal hygiene and mouth care
- Continence and bladder and bowel care
- Record keeping
- Safety of patients with mental health needs
- Privacy and dignity, and
- Communication.

106 NHS trusts were expected to develop and implement local policies that ensured compliance with the benchmark standards.

107 In 2001 the Department of Health also issued a series of documents about consent to treatment. They are listed in circular *HSC 2001/023*, called *Good practice in consent – Achieving the NHS Plan commitment to patient-centred consent practice*, which provides an overview of the Government's commitment to patient-centred consent practice. *Seeking consent: working with people with learning disabilities* (Seeking Consent) provides comprehensive guidance about what is expected of clinical staff and covers issues such as how consent should be obtained and, where a person is unable to consent for themselves, how healthcare staff should act in the patient's 'best interests'. The guidance is clear that where there are difficulties in obtaining consent, discussions about consent and the rationale for any actions taken under 'best interest' principles should be recorded.

108 In January 2003 the Department of Health published comprehensive guidelines about discharging patients from hospital called *Discharge from hospital: pathway, process and practice* (Discharge from Hospital). The lengthy guidelines are in the form of a workbook and include principles for good practice as well as introducing a range of tools to assist professionals involved in the discharge process. Amongst other things, it expects organisations to have arrangements to ensure that people can be safely transported home or to another setting and that relevant information, such as

discharge summaries and care plans, transfer on a timely basis. Amongst the document's *'key messages'* are:

> *'Ensure individuals and their carers are actively engaged in the planning and delivery of their care.*
>
> *'...*
>
> *'Agree, operate and performance manage a joint discharge policy that facilitates effective multidisciplinary working at ward level and between organisations.*
>
> *'On admission, identify those individuals who may have additional health, social and/or housing needs to be met before they can leave hospital and target them for extra support.*
>
> *'...*
>
> *'Consider how an integrated discharge planning team can be developed to provide specialist discharge planning support to the patient and multidisciplinary team.'*

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

110 In March 2000 the Clinical Standards Advisory Group[3] issued a report called *Services for Patients with Pain*. They recommended the following:

> *'NHS Trusts*
>
> - *Ensure that patients undergoing painful procedures have access to an acute pain team led by a doctor and at least one specialist nurse, working closely with pharmacists and physiotherapists.*
> - *Ensure reasonable access to a pain management programme for patients with high levels of distress or disability as a result of chronic pain.*
> - *Give a higher priority to effective pain management in A&E departments.*
> - *Ensure that staff who manage patients with pain are adequately trained.'*

Professional standards

The General Medical Council

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

[3] The Clinical Standards Advisory Group was established in April 1991 as an independent source of expert advice to UK Health Ministers and to the NHS

112 Paragraph 5 of Good Medical Practice, 2001, says:

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

The Nursing and Midwifery Council

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

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

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

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

115 Paragraph 2 of the Code of Conduct said:

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

'...

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

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

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

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

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

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

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

Complaint handling

Council complaint handling

117 The *NHS and Community Care Act 1990* imposes on social services authorities a statutory duty to provide a complaints procedure. Statutory guidance has been issued by the Department of Health and authorities must have regard to it when managing complaints about their service. The statutory complaints process applicable to this complaint was that contained within the *Complaints Procedure Directions 1990* (these have now been superseded by the *Council Social Services Complaints (England) Regulations 2006* and associated guidance, for complaints made after August 2006).

118 The 1990 Directions established a three-part process consisting of a first, informal, stage aimed at resolving the complaint at a local level, but which progressed to the formal second stage if the complainant remained dissatisfied. The matter was considered at the second stage by the designated complaints officer and an investigator might be appointed. If the complainant remained dissatisfied at the end of this stage of the process, he or she had the right to request an independent review by a panel set up by the council to review the stage 2 investigation. The panel did not carry out a fresh investigation, nor could it consider any aspect of the complaint that had not already been considered at an earlier stage. The panel had no power to make binding findings, but could make recommendations to the council to resolve the complaint. If the council rejected the findings it had to provide reasons for doing so.

NHS complaint handling

119 Prior to 30 July 2004 complaint handling in the NHS was subject to various Directions produced by the Secretary of State for Health. The 1996 Directions and subsequent amendments required NHS trusts to have written procedures for dealing with complaints within their organisation (known as local resolution) and to operate the second element of the complaints procedure (independent review).

120 The objective of the Directions was to ensure that complainants were treated courteously and sympathetically and that their complaints were properly addressed, and each trust and authority was required to appoint a complaints manager to deal with the first, local, level of the process and a convener to manage the second, independent, level. Any complainant who was dissatisfied with the outcome of the first stage local investigation was entitled to request the holding of an independent review panel; although the convener was not obliged to comply with this request he or she was obliged to consider it, taking clinical advice where appropriate.

Complaint handling by the Healthcare Commission

121 For complaints commenced under the former complaints process but not completed before 30 July 2004 (the date the *NHS (Complaints) Regulations 2004* – the Regulations – came into force), transitional arrangements applied. Where by that date an investigation of a complaint had been conducted and completed by the complaints manager of the body complained about, the second element of the complaints procedure was conducted by the Healthcare Commission in accordance with the Regulations

unless the complainant had requested an independent review panel under the former procedure.

122 *Part III* of the Regulations (Regulations 14 to 19) sets out the statutory requirements on the Healthcare Commission when considering complaints at this second level.

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

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

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

Section 3: the investigation

Background

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

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

Complaint (a): provision of care and complaint handling

127 Mr Cannon's parents complain that their son was provided with inadequate care by the Council, which led to his injury and, ultimately, his death. They believe the Council failed in its duty to keep their son safe while he was in its care as a result of poor care planning, poor supervision, weak management and inadequate staffing, including training and induction. They also say the Council repeatedly failed to properly investigate the circumstances of their son's injury or to take any responsibility for the part the failings played in his injury and subsequent death.

Key events

128 Mr Cannon had received respite care at the Grange on many occasions in the past and his most recent stay had been in December 2002. He went to the Grange again on 17 June 2003 for two weeks while his mother and stepfather went on holiday. On this occasion he sustained the fracture which led to his admission to the Trust during the night of 26/27 June 2003.

129 On the night that Mr Cannon sustained his injury there were three care workers on duty looking after all the permanent and respite residents; one care worker providing one-to-one care for a resident and a sleeping-in officer. Of the three care workers on duty, one was a permanent member of staff employed by the Council (the Second Care Worker). The other two carers were agency staff engaged by the Council. The senior officer on sleeping-in duties was also employed by the Council. One of the agency care workers had worked at the Grange for about two years (the Third Care Worker) and the other agency care worker had worked at the Grange for approximately one year (the First Care Worker). On the night in question, the Second Care Worker was assigned to the Chelsea Unit, the First Care Worker was assigned to the Wedgewood Unit and the Third Care Worker was assigned to the Darby Unit, which was the Unit accommodating those receiving respite care and, thus, where Mr Cannon was accommodated. No further reference is made to the care worker (also employed by the Council) providing one-to-one care to a resident and who was not involved in events referred to in this report.

130 When starting her shift at about 10.00pm on the night of 26 June 2003, the First Care Worker went to put her belongings away and came across Mr Cannon sitting on the floor by the door of his room *'sort of rocking'*. According to the First Care Worker *'No other worker was present as they were all outside having a tea and cigarette break'*. The First Care Worker says she spoke to Mr Cannon but he did not respond so she touched the top of his arm and asked him to stand up which he did unaided. The First Care Worker then noticed that Mr Cannon had wet his pyjamas. Holding the First Care Worker's hand, Mr Cannon walked slowly to his bed, a distance of 5 to 6 feet. Then, according to the

First Care Worker, Mr Cannon *'lay on the bed and I changed him, then left to continue to put my things away. On the way back I checked on* [Mr Cannon] *and he was still in bed, lying down awake'*.

131 Notwithstanding that the Council contends otherwise, it appears that at no stage between that chance encounter at about 10.00pm and, at the earliest, 2.00am was any care and/or attention provided to Mr Cannon. I do not consider that that chance encounter equated to the provision of regular support and supervision or represented a planned approach to monitor the safety of Mr Cannon.

132 At the start of their shifts at 10.00pm on 26 June 2003 the Second and Third Care Workers were engaged in general duties away from the Units to which they were assigned that night. They continued to be so engaged until, at the earliest, 2.00am. In evidence given to the Registered Manager of the Grange the day after the incident, the First Care Worker indicated that she too was engaged on general duties after handover away from the Unit to which she had been assigned. The evidence is that the First Care Worker was *'still downstairs'* at 12 midnight. At about 12.15am the First Care Worker told the Second and Third Care Workers about finding Mr Cannon on the floor with wet pyjamas. In statements provided by the Second and Third Care Workers within two days of the incident, neither said that she had checked on Mr Cannon at that stage, although the Second Care Worker subsequently said that she had checked on Mr Cannon after she had *'finished her task'*. The Second Care Worker has also stated in recent evidence provided to the Council (December 2008) that she checked on Mr Cannon *'after handover and then half hourly'*. I do not accept that evidence.

133 When the general duties were finished at about 2.00am, each of the three care workers went to the respective Units to which they were assigned. The Third Care Worker thus went to the Darby Unit. In a statement made by the Third Care Worker within two days of the incident she did not say, as the Council now asserts, that she checked on Mr Cannon at 2.00am but stated that she stationed herself in the doorway of the Darby Unit at that time and remained there until she heard Mr Cannon *'calling/moaning'* at about 3.15am. Evidence to the Coroner suggests that the Third Care Worker was seated approximately 12 feet away from Mr Cannon's room, the door to which was open. The Third Care Worker was crocheting and reading with the TV on *'for background noise'*.

134 Thus, the evidence suggests that between being helped to bed by staff at about 9.30pm and when he started to *'call/moan'* at about 3.15am, Mr Cannon was seen once, quite by chance, by the First Care Worker at about 10.00pm. The Council asserts, however, that Mr Cannon had been *'regularly monitored between 10 pm and 2 am'*. In my view, that assertion does not accord with the most contemporaneous evidence. The Council also asserts that between 10.00pm and 2.00am the First Care Worker was *'walking around all 3 units comprised in the Grange generally checking that all residents were well'*. Again, that assertion does not accord with the most contemporaneous evidence. In my view, no monitoring of Mr Cannon took place between 9.30pm and, at the earliest, 2.00am.

135 Further, the Council's present position that staff at the Grange had acted in accordance with the care assessment documents in that Mr Cannon had been regularly monitored is inconsistent with:

- the recommendation made by the registered Care Manager as the result of an investigation he carried out immediately following the incident that:

  'All through [although?] *a staff member is always assigned to the special needs unit (Darby) it appears that they sometimes leave the Unit to complete other duties. This does not appear to be appropriate given the level of support required by some service users'*

- the conclusions in the first independent investigation report (dated 18 September 2003) that:

  '... interviews with staff indicate that Risk Management guidelines to ensure [Mr Cannon's] *safety were not followed. This led to* [Mr Cannon] *being unsupervised for periods of his stay while staff carried out duties/tasks in other areas of the building'*

  and

  'In summary, the care offered to [Mr] *Cannon during his respite stay at the Grange from 17.6.03 to 27.6.03 was of a standard that does not meet the minimum requirements of the NCSC* [National Care Standards Commission]'

  and

  'While individual staff acted with best intent to meet [Mr Cannon's] *individual needs, corporate failure ultimately led to a failure to meet* [Mr Cannon's] *care needs during his stay'*

- the Hearing Panel's decision at Stage 3 of the Council's complaints procedure (complaint relating to Mr Cannon's injury while at the Grange) that:

  'the Panel had no hesitation in upholding the complaint ***which was admitted to by the service***' (emphasis added)

  and

  'the Panel strongly sympathised with [the complainants] *in respect of the whole issue and listened most carefully to their representations on the standard of care that* [Mr Cannon] *received at his last stay at the Grange. The Panel agreed with the appellants* ***and the service's view*** *that the standard of care* [Mr Cannon] *received fell below what he should have been given'* (emphasis added).

136 When the Third Care Worker heard Mr Cannon *'calling/moaning'* at about 3.15am on the night/morning of 26/27 June 2003, she thought he wanted to go to the toilet. [The Second Care Worker] turned back the bedclothes which were not in disarray and swung Mr Cannon's legs round and helped him out of his bed. In a statement provided by the Third Care Worker within two days of the incident, she said *'I tried to take him to the toilet but he could not weight bear so I helped him to the floor and went for assistance.* [The Second Care Worker] *could not get* [Mr Cannon] *to the toilet so we put* [Mr Cannon] *back to bed and called* [the sleeping-in senior officer on duty] *at approximately 4.05am'*.

137 In her statement made within three days of the incident the Second Care Worker said *'At about 3.45* [the Third Care Worker] *came and asked me to look at* [Mr Cannon]. [The Third Care Worker] *had tried to help* [Mr Cannon] *to the toilet and when he could not walk she helped him to slide down to the floor. We helped* [Mr Cannon] *back to bed but when we left he still wanted the toilet. So we lifted him to the toilet then back to his bed.* [Mr Cannon] *appeared comfortable when still but movement caused him pain'.*

138 In her statement made the day following the incident, the First Care Worker said:

> *'At about 3pm* [this must mean am] *I heard* [Mr Cannon] *shouting out loud. I did not go down as I know someone was on the floor and would call if they wanted help.* [Mr Cannon] *screamed out again louder while I was checking the residents. I went back into the lounge when* [the Third Care Worker] *came upstairs and asked me if I had a minute to spare to come down to see* [Mr Cannon] *with her. We collected the lady from Chelsea unit on the way down.* [The Third Care Worker] *said she thought the reason why he screamed was because he wanted the toilet but he couldn't walk, so she asked me to help her take him. One carer said we should look for the commode and the other one said no take him to the toilet as it isn't far. All three of us helped him to the toilet and we waited 5 or 6 minutes while he went. He was rubbing his legs and making a face. When he finished we tried to help him stand but he couldn't put any pressure on his left leg so all three of us helped him back to his room – he didn't moan he just grimaced. We put him to bed and* [the Second Care Worker] *went to find* [the sleeping-in officer]. *She came down and tried to talk to* [Mr Cannon]*, but he didn't respond to her. Then* [the Second and Third Care Workers] *lifted him and* [the sleeping-in officer] *stood opposite to see what the problem was. She asked him to walk but he couldn't put his left leg down.'*

139 A contemporaneous memorandum on 27 June 2003 states that:

> '[the sleeping-in officer] *was called up at 4.05 as there was concerns regarding Mark Cannon (special needs respite).*
>
> *'Mark was very distressed & unable to weight bear on his (L) leg. The night staff stated that Mark had gone to the toilet approx 1/half hours prior to this & at that time showed no signs of pain or distress or problems weight bearing.*
>
> '[The Third Care Worker] *stated that she was outside Marks room discreetly monotering* [sic] *him & that he seemed fine until he cried out, she assumed he wanted to go to the toilet again & it was on this occasion that he showed the signs of pain distress & inability to weight bear on his (L) leg.'*

140 No other evidence supports the contention that Mr Cannon had gone to the toilet before 3.15am. The contemporaneous evidence of the care workers is moreover inconsistent. According to the contemporaneous evidence of the Third Care Worker, the care workers tried to take Mr Cannon to the toilet but he could not weight bear on his left leg so the care workers put Mr Cannon back to bed and went to the sleeping-in officer for assistance. The contemporaneous evidence of the First and Second Care Workers, however, is that the care workers did lift Mr Cannon to the toilet and back to his room before involving the sleeping-in officer.

141 There is thus some discrepancy in the timing but it appears that approximately one hour passed before care workers called the senior (sleeping-in) officer. It is not clear what happened during the whole of this period but it is likely that Mr Cannon continued to be in severe pain. Once the senior officer became involved appropriate actions appear to have been taken; an ambulance was called and Mr Cannon was taken to hospital at 5.00am, accompanied by the care worker assigned to the Darby Unit.

142 The Grange closed in 2007 and its services were transferred to new facilities.

143 On 7 July 2003 Mr Cannon's father wrote to the Council to complain about the injury that his son had sustained, which he believed was due to the *'seriously deficient care'* provided at the Grange. On 16 July 2003 Mr Cannon's mother submitted a formal complaint regarding her son's care, expressing her anger about what had happened and her anxiety about the conflicting accounts given about the circumstances of her son's injury. The complaint was accepted for investigation under the terms of the relevant legislation and it was acknowledged as a *'serious complaint'*.

144 During the following two years a confusing series of contradictory communications from the Council left Mr Cannon's mother feeling frustrated and uncertain about the progress of her complaint. The Council appears to have taken the view that the police investigation and the Coroner's inquest had resolved the family's complaint. The family did not take this view. Mr Cannon's mother resubmitted her complaint in July 2004 and asked for an investigation to take place but in March 2005, following the outcome of the inquest, the Council terminated the complaint on the basis that all the outstanding matters had been dealt with. The complaints process was only resumed when Mr Cannon's mother complained to the Local Government Ombudsman.

145 The Council's complaints process was finally concluded in August 2006 when a Panel consisting of councillors and a lay chairman considered Mr Cannon's mother's complaint and concluded that there had been shortcomings in the care provided. His mother was paid £250 to reflect the inconvenience of having to make her complaint. She was not satisfied with the outcome.

Mr Cannon's mother's recollections and views

146 Mr Cannon's mother told my investigator that she and her husband had been on holiday at the time of the injury and this was the reason her son had been placed in respite care. She said he received respite care at least once a year and at the time he went into the Grange on 17 June 2003 he had been well, other than the usual problems caused by his learning disability. She said her son was rarely ill and she and her husband felt content to go on holiday and leave him in the care of the home.

147 Mr Cannon's mother said that on 27 June 2003 she and her husband received a message informing them of her son's injury. She said she telephoned the Grange to try to find out what had happened and could find no one to answer her questions. Because she had eventually been reassured about her son's condition she did not return from holiday immediately. She returned on 2 July 2003 and went immediately to see him and it was only at this stage that she realised how serious his injury had been.

148 Mr Cannon's mother said it was not until three weeks after her return from holiday that she was able to speak to the temporary manager of the Grange. She said she was extremely unhappy about the account given to her regarding the circumstances surrounding her son's injury. It was clear to her that her son had not been properly cared for. He should never have been left alone in such a large facility where staff were clearly overstretched. Mr Cannon's mother said staff admitted her son was left unattended for two hours and staff who should have been supervising him were elsewhere in the facility. She said staff had told her that they had checked on him but this could not have been the case. Mr Cannon's parents felt staff at the home did not want to talk to them and they never received a full explanation for their son's fall. One carer had told her that her son had been crying out from his bed but others gave a different version of events, suggesting that he had been walking about when he was found. Mr Cannon's mother said that there had been no handover from one shift to the next and the carers on duty on the night of his injury did not even know that her son was epileptic. She felt, based on her knowledge of her son, that he had got up during the night, had had a seizure and fallen, breaking his leg during the fall. She added that Social Services had contacted her as soon as she returned from holiday and they were very helpful over the coming weeks.

149 Mr Cannon's mother said when her son was found, crying in pain, staff had assumed he wanted to go to the toilet and had picked him up and tried to walk him to the toilet which must have been extremely painful for him. Because he was in such terrible pain care staff had woken up the senior staff member on duty but it was still two hours before an ambulance was called. Mr Cannon's mother said she could not understand why her son was left in such a bad condition, crying in pain, for so long before an ambulance was called. She and her husband both felt the explanations they had been given were incomplete, contradictory and totally unsatisfactory. She also told my investigator that her son's epilepsy mat had definitely been removed by staff at the Grange after she and her husband had taken it with them and had put it in place. They had shown staff how to use it and given them details of who to contact if it did not work. It was very sensitive and had a portable walkie-talkie type alarm. She said it was probably going off regularly and staff had removed it but no one had admitted to this. Mr Cannon's mother confirmed that the epilepsy mat was always in use when her son was at home. The alarm would sound every time he moved and she and her husband would usually check on her son to make sure he was okay. She said the alarm would stop sounding by itself after a few moments when he had settled down. She confirmed that, following the injury, she collected the mat from the Grange and tested it and found it to be in full working order.

150 Commenting on the investigation carried out by the Council into events at the Grange, Mr Cannon's mother said she was not happy with its attitude as it had not identified the cause of her son's fall. She said that she was extremely unhappy that staff at the Grange who had found Mr Cannon after his fall had exacerbated his injury because they were not properly trained. The care home was just not running as it should have been and she wanted the events which took place that night fully investigated.

151 Mr Cannon's mother said her son was eligible for full-time care but she had decided to keep him living at home for as long as possible as she knew he would not last as long in full-time care and he loved being with his family. She knew

one day he would have to go into full-time care but dreaded this. She also said at no time during Mr Cannon's life had any of his doctors commented on his life expectancy. It just never came up. She had expected him to live for some considerable time.

Mr Cannon's father's recollections and views

152 Mr Cannon's father told my investigator that the circumstances of his son's fall had never been properly explained. There were several conflicting accounts and even the time of the injury could not be established with any precision. Some time in the early hours of 27 June 2003 Mr Cannon was found either in bed, crying out in pain, or lying on the floor, crying out in pain. It had been suggested that, having had his accident, he had climbed back into bed by himself. At the inquest it had been established that, having broken his leg, it would have been extremely difficult for him to get back into bed without assistance. Mr Cannon's father said, in his opinion, it was likely that carers found his son difficult to manage and he was left unsupervised. It is possible that he may have wanted to go to the toilet during the night and a carer had tried to restrain him and put him back to bed. He said he may have fallen while being restrained and as a result had broken his leg. Mr Cannon's father said he felt sure the full facts of his son's injury had not been uncovered. He found the account given by the staff at the Grange very difficult to accept.

The Council's actions

153 The following information has been taken from the Council's complaints files and other information provided to me by the Council.

Management arrangements at the Grange

154 The Grange was a registered care home for people with learning disabilities owned by the Council. The home had 37 places, 5 of which were set aside for respite care. The home's staff – other than the Manager – were directly employed by the Council or were agency staff engaged by the Council. The Manager was employed by the Avenues Trust.

155 The Council entered into a contract with the Avenues Trust effective from 1 April 2002. Under the heading 'The Contract Agreement' it stated *'That the Avenues Trust has a Management Agreement with Havering Social Services for the management of the Grange. The term of the contract will be 1 year and reviewed thereafter on a 6 monthly basis'*. The Contract Agreement also stated that it could be *'terminated by mutual agreement, giving one month's notice'*.

156 Under the contract, the Avenues Trust was to provide a registered Care Manager. The Registered Manager of the Grange was only in attendance at the Grange for up to two-and-a-half days each week. The Deputy Manager was a Council employee who had responsibility for the operational running of the Grange and had overall responsibility when the Registered Manager was not in attendance.

157 Under the heading 'Staffing', the contract provided that:

> *'All staff currently employed at the Grange will remain on their current terms and conditions and will remain employed and therefore pay-rolled by Havering Social Services. They will report through the operating line management structure ie through the Registered Manager and will be subject to Havering Social Service employment policies and procedures.'*

158 The minutes of a contract monitoring meeting held on 11 July 2002 record that *'Havering Council are to take responsibility for the overall operation (control) of the homes'*.

159 When providing information about the staffing and management arrangements at the Grange at the relevant time, the Council's Learning Disabilities Service Manager informed my investigator that she had been involved in the management of the Grange for some time. In May 2003, a month before the incident in question, she had taken over line-management responsibility for the Grange.

Mr Cannon's injury at the Grange and his parents' complaint to the Council

160 The circumstances of Mr Cannon's injury have been described above. The Learning Disability Service Manager with responsibility for the Grange (the Learning Disability Service Manager) asked the Manager of the Grange to investigate what had happened and report back to her. The Registered Manager interviewed the Second and Third Care Workers and the sleeping-in officer over the weekend of 28/29 June 2003. He obtained a statement from the First Care Worker the day following the incident and then spoke to her on the telephone to clarify some of her statement. The Manager concluded that:

> *'I am unable to give a clear conclusion of how Mark Cannon broke his hip* [sic] *while on Respite Care at the Grange.*
>
> *'The most likely explanation is that Mark had a seizure earlier in the night and was found by* [the First Care Worker] *soon after. The fact that* [Mr Cannon] *was incontinent when she found him would suggest this.* [Mr Cannon] *is thin and frail and could easily damage himself during a seizure. However the* [First Care Worker] *states that he walked back to bed 5 feet away with very little support which with a broken hip* [sic] *would be difficult. She does state that he walked slowly. The lack of reaction to the broken hip* [sic] *could be due to* [Mr Cannon] *being in recovery from seizure.'*

161 Among the recommendations made by the Manager were:

> *'All through* [although?] *a staff member is always assigned to the special needs unit (Darby) it appears that they sometimes leave the unit to complete other duties. This does not appear to be appropriate given the level of support required by some service users.*
>
> *'The use of alarm mats need to be considered for some respite care users such as a mat fitted next to a bed would be set off when a service user places their foot on it and so alerting the night staff. The use of similar devices attached to beds, sensory lights may also need to be considered.'*

162 It was considered that the report by the Manager was incomplete so the Learning Disability Service Manager commissioned a report from an independent person in early August 2003.

163 On 7 July 2003 Mr Cannon's father wrote to the Director of Social Services in the strongest terms to *'complain about the seriously deficient care'* that his son had received at the Grange. He said his son was recovering from surgery due *'directly to injuries mysteriously sustained while in respite care'*. He continued:

> *'Appropriate care while in your safekeeping and guardianship would have precluded these catastrophic injuries and ongoing consequential problems, pain and anguish to Mark and all his family.'*

164 Mr Cannon's father cast doubt on the account given by the Grange that his son was found in bed with his injury. He expressed deep distress about the pain that he must have suffered when he was returned to his bed and left there. He said the orthopaedic surgeon at the Trust had confirmed the injuries could not have been sustained in the way that the Grange had claimed. He went on to ask for a full investigation of the circumstances surrounding the injury and put a list of specific incidents to the Director of Social Services.

165 On 16 July 2003 Mr Cannon's mother also made a formal written complaint to the Council regarding her son's care. She said the family had been told conflicting stories about what had happened to him:

> *'According to the Orthopaedic Surgeon there was no way he could have an injury so severe in bed. It could only have been sustained by a fall and if he had been picked up and put back to bed it could have caused further injury … . As there are conflicting stories, I feel that there should be an in-depth inquiry as the circumstances are very suspicious.'*

The Council's investigation

166 On 8 July 2003 the Personal Assistant to the Director of Social Services wrote to Mr Cannon's father saying the Director wanted to *'acknowledge that this is a serious complaint and therefore a copy of your letter has been passed to* [the] *Customer Relations Officer who will take this complaint through our complaints procedure'*. On 30 July 2003 a customer relations assistant wrote to Mr Cannon's parents separately informing them that the First Independent Investigator, whom she described as the Community Learning Disabilities Team Manager, would be investigating their complaint, and of their right to a Stage 2 investigation if they remained dissatisfied. The letter was headed *'CHILDREN ACT 1989 & NHS & COMMUNITY CARE ACT 1990 Stage 1 complaint'*.

The report of the First Independent Investigator

167 The First Independent Investigator's report was sent to Social Services on 18 September 2003. She said her investigation had been carried out by means of interviews with six staff members at the Grange including the Manager of the home and the three staff members who had been on duty on the night of Mr Cannon's injury. She had also examined evidence provided by the Learning Disability Service. Several Learning Disability Service staff members were also asked to provide evidence, as was the Manager of St Bernard's Day Care Centre. In her report the First Independent Investigator set out a detailed sequence of events based on the statements provided by staff at the Grange. Her account provides a description of events at the time of the injury. Key sections of the report are set out here together with her findings:

> *'Mark was admitted for respite care on 17.6.03. During the period from 17-26.6.03, 6 seizures were recorded on the record of seizures and in daily records. At home Mark* [used] *a piece of equipment to detect him moving from his bed. Staff at the Grange were shown by Mark's family how to use the mat. Staff at the Grange stated the equipment was not functioning during Mark's stay … They took no action to notify management or community nurses of the failure of the equipment. …*
>
> *'Interviews with staff at the Grange established that on the evening of the 26 June 03, Mark had been assisted to go to bed at approximately 9.30pm. The epilepsy*

mat that would detect movement was not in place. Mark was found on the floor, incontinent of urine, at approximately 10.00pm by an agency worker [the First Care Worker] *arriving for her shift. There were no care staff in the vicinity. At this point Mark was not distressed, and was able to stand and walk to his bed unaided where he was changed into dry clothing by* [the First Care Worker] *and helped back to bed.* [She] *did not mention the incident during the handover. She did advise regular staff of the incident approximately 2 hours later.* [The First Care Worker] *had worked at the Grange for approximately the past year ... She had met Mark once ... during his current stay and was not fully aware of his care needs. No incident form was completed. No seizure was observed and at no time did staff connect the incident of finding Mark incontinent with the possibility that he had a seizure.* [The Second Care Worker] *employed by* [the Council], *regular staff at the Grange, checked on Mark once alerted to the earlier incident and found him to be "as usual". Mark showed no signs of distress. He was in bed at this time.* [The Third Care Worker], *agency staff, previously employed by* [the Council] *and regular staff at the Grange was allocated to Darby Unit* [where Mark stayed] *on 26.6.03. She was aware that Mark had seizures and therefore once all residents were settled, at approximately 2.00am, located herself outside Mark's room. Around 3.15am* [the Third Care Worker] *heard Mark moaning as if awakening. After a few minutes she went to assist him to the toilet.* [She] *helped Mark to the side of the bed. He was in discomfort;* [the Third Care Worker] *thought he had cramp and rubbed his legs.* [She] *tried a second time to help Mark off the bed, but realising there was something wrong, lowered him to the floor and went for help.*

'[The Second Care Worker] *and* [the First Care Worker] *came to Mark's room.* [They] *tried to help Mark walk to the toilet but were unable to.* [They] *then carried Mark to the toilet, waited while he used the toilet then carried him back to his room. At 4.05am* [the Second Care Worker] *went to call* [the] *senior officer, sleeping in. An ambulance was called at 4.20am, arriving at 4.40am. Mark was taken to hospital at approximately 5.00am accompanied by* [the Third Care Worker]. *Mark's sister was informed by telephone message at 6.30am and* [the Senior Officer] *gave basic information at 7.14am when the call was returned* [by Mr Cannon's sister]. *Staff at the Grange checked on Mark's progress by telephoning the hospital but did not make contact with members of Mark's family.'*

168 The First Independent Investigator then provided a description of the assessment and care management documentation produced by the Learning Disability Service which indicated the levels of care Mr Cannon required, particularly when in respite care.

'Mark had a Community Care Assessment carried out in January 2002 [by the Learning Disability Service]. *The assessment identified that Mark must be monitored at all times. A Care Plan was drawn up identifying Mark's support needs and his carer's respite needs. Mark was assessed as needing 1:2 staffing ... Initially Mrs Handley requested 1:1 staffing during respite admissions. Following discussion with his family, Mark's mother agreed to the Care Plan. The Care Plan identifies that Mark is fully continent except when he has ... seizures. It also identifies a risk that Mark may be vulnerable during the night as he may wander, and has had seizures that have led to him falling*

and injuring himself. It further records a risk if there is no one around to support and supervise Mark.'

169 The First Independent Investigator then described the documentation from the Grange relating to the planning of Mr Cannon's care during his respite stay:

> *'Staff at the Grange had copies of Mark's Community Care Assessment and his Care Plan ... There is no provider Care Plan available from the Grange to direct staff carrying out Mark's care during his stays.'*

170 The First Independent Investigator described the protocol which had been implemented by the Council for use in residential and day care units for the management of epilepsy:

> *'A record of seizures* [had] *been maintained, although the information recorded* [was] *of a basic level and not in line with the ... protocol. A number of other forms* [were] *available within the protocol to enable staff to be fully equipped to deal with an individual's epilepsy* [such as] *Check list for Service User; Personal Characteristics relating to Seizures; Medication agreement forms. None of these forms were found in Mark's records at the Grange.'*

171 The First Independent Investigator commented on the Grange's most recent National Care Standards Commission inspection report which was dated 31 March 2003:

> *'care plans must identify all areas of need and be in enough detail for anyone entering the home to have knowledge of how to care for that person.*
>
> *'...*
>
> *'The inspection found that care plans lacked the depth of information to make them workable documents. The lack of a plan for Mark is consistent with the* [National Care Standards Commision] *findings.'*

172 Noting the absence of a Provider Care Plan for Mr Cannon, the First Independent Investigator found that a proactive risk assessment had been completed at the Grange for him in May 2001. She said:

> *'This document* [identified] *a high risk of an incident if Mark* [was] *left on his own. The "management controls necessary"* [indicated] *that "Mark must not be left alone" and that staff should "... summon additional staff to sit with Mark" whilst undertaking other duties. And continues "Mark must never be left on his own, other than when he is in bed"...'*

173 In commenting on the draft of this report the Council has provided further detail about the information contained in the May 2001 risk assessment:

> *'Mark has epilepsy and suffers quite severe seizures; staff to observe.*
>
> *'Mark is capable of getting out of bed to use the bathroom; staff to be extra vigilant during the early morning hours and to regularly check on Mark.*
>
> *'Mark is at high risk when staff need to support other residents in the unit. At such times Mark must not be left alone; staff are to activate the call alarm to summon additional staff to sit with Mark.*

> *'When Mark has a seizure staff are to indicate type and length of seizure on chart. Staff to ensure area clear of objects which may cause injury during the seizure. Staff to place Mark in recovery position if necessary.*
>
> *'Mark must never be left on his own other than when he is in bed, he must be regularly supervised in this activity.'*

The Council has also referred to an Assessment and Care Management Form (Form CM6) which concluded that Mr Cannon required a 1:2 staffing ratio during the day and evening with regular monitoring during the night to ensure that he was well and had not had a nocturnal seizure. But the CM6 also says that *'the respite environment needs to be able to provide adequate staffing ratios within the unit to ensure that it is staffed at all times during the night. Mark appears to be more vulnerable during the night as he will get up and wander and does have seizures which have led to him falling and injuring himself'*.

174 The Council accepts the risk assessment had not been updated but considers there was no evidence that Mr Cannon's needs had changed in that time. Prior to his respite stay in June 2003, Mr Cannon's mother completed on his behalf a form setting out 'Respite Care Medication Details'. On that form it recorded that Stesolid should be given rectally *'if a seizure is severe or giving stress'* and *'if* [a] *seizure lasts more than 20 minutes …'*. Under the heading 'Additional Information' the form recorded that Mr Cannon *'often gets out of bed at night so needs constant monitoring in case of seizure which will cause injury. Epilepsy alarm supplied'*. In commenting on a draft of this report the Council has said that this document was not a formal assessment but a document prepared by Mrs Handley containing her personal opinions.

175 I also note that Mr Cannon apparently fell out of bed on the morning of 18 June 2003, just over one week before the incident which is the subject of this complaint. In response to the question *'Did any other factors or persons contribute to the incident'* on the Accident/Incident Report Form, the answer *'Yes'* is given and *'person has epilepsy'* is inserted. In completing the section of the form requesting details of further measures or other action intended to be taken to prevent any recurrence, the response *'closer supervision'* is given.

176 The Council has said that a seizure chart was completed by the Grange after every seizure and on every day even if none was recorded. This is inconsistent with the fact that when Mr Cannon was found at about 10.00pm on 26 June 2003 sitting on the floor by the door of his room incontinent, no entry was made by any of the care workers on duty when it was highly likely, and the Coroner so found, that Mr Cannon had had a seizure.

177 Continuing her description of the events at the Grange on the night of Mr Cannon's injury, the First Independent Investigator said:

> *'When staff arrived for night duty, there were no staff in Darby Unit. During the handover from the afternoon shift … to night staff … Mark was alone in Darby Unit. There was no alarm system in place to call staff in an emergency. From 10.00pm to 2.00am night staff were involved in handover, completing tasks, helping residents with personal care and to get ready for bed. There were no specific arrangements to ensure Mark was observed during this period. The Risk Assessment* [prepared in May 2001] *stated that "Mark must never be left on his own, other than when he is in bed …".'*

178 The First Independent Investigator commented on the staffing arrangements at the Grange:

> *'The registered home manager post is currently being covered by a senior manager of Avenues Trust, who are contracted to manage the service provided at the Grange. Due to other commitments, he is only available approximately 2.5 days per week. The registered home manager had never met Mark and was unaware of the lack of a detailed care plan for staff to work to. On the whole, the Management of the home is left to the deputy manager. On 26 June there were 27 permanent residents and 2 residents for respite care ... On the night of 26.6.03 there were 4 staff on duty, including a 1:1 worker for another resident in Wedgewood unit. ... Between 12.00 midnight and 2.00am staff were carrying out general duties and no staff were located on Darby Unit. A high level of agency staff* [was] *in use at the Grange, due to recruitment and absence issues.*
>
> *'According to senior staff ... New staff and agency staff are given basic induction when coming to the unit for the first time in respect of fire procedures, tour of building and whereabouts of records/care plans. Written information was available listing the tasks for am and pm shifts. Information is also available on action to take in a variety of emergency situations. New staff are expected to take advice from permanent staff members. It* [was] *recognised that in reality, it is unlikely that agency staff will have time to read through all the documentation due to the work pressure. Agency Worker* [the First Care Worker] *received minimal induction to the building. She was aware of being given information during handovers on residents' needs. She* [was] *not aware of any induction regarding procedures following incidents, or being made aware of procedures relating to emergencies.'*

179 The First Independent Investigator concluded her review of the evidence she had obtained by describing the arrangements in place at the Grange for the management of clients with epilepsy:

> *'Following the introduction of the* [Council] *protocol for administration of rectal diazepam* [the Learning Disability Service] *worked with the Grange staff to introduce guidance on management of Epilepsy. Staff at the Grange received training in Epilepsy, recording seizures and giving rectal Diazepam. Follow-up training is scheduled regularly, but poorly attended by staff at the Grange.* [The Learning Disability Service] *identified that the Avenues Trust also has its own policies regarding management of Epilepsy. Staff interviewed referred only to the guidance implemented through* [the Learning Disability Service]*'s training programme. Records kept at St Bernard's show that information required to assist staff in the management of Mark's epilepsy was available.'*

180 The First Independent Investigator then presented the conclusions of her investigation:

> *'The fact that the homes manager of a large residential home is not available for half of the week leaves the service with weak management, and a lack of monitoring/management supervision.*

'On the basis of all the information obtained, it is not possible to identify a definite cause, or time, at which Mark fractured his hip [sic]. *However, it seems likely that the fracture occurred after 9.30pm and before 3.00am on 27.6.03. Mark was found on the floor, incontinent, by an agency worker coming on duty, who was unaware of Mark's care needs. The information was not passed to staff who knew Mark for approximately 2 hours. The lack of communication regarding Mark's needs, and the delay in communication regarding the incident, may have compromised Mark's safety. The fact that Mark was incontinent may indicate that he had a seizure that was not observed by staff. The night staff did not take immediate action to call for assistance when it was noted that Mark was in pain and unable to weight bear. With best intent, 3 night staff at the Grange carried Mark to the toilet. This action may have aggravated the injury and appears to have caused further pain to Mark.*

'Whilst the staffing levels were appropriate to the registration requirements, interviews with staff indicate that Risk Management guidelines to ensure Mark's safety were not followed. This led to Mark being unsupervised for periods of his stay whilst staff carried out duties/tasks in other areas of the building. In turn this left opportunity for Mark to sustain an injury without this being witnessed and therefore immediate action could not be taken.

'Despite the training undertaken by the [Community Learning Disability Team] *in respect of Epilepsy, the information recorded in the Record of Seizures Charts indicates that staff do not understand/appreciate the importance of accurate recording. The Grange staff did not have records relating to the presentation of Mark's epilepsy, or detailed guidance on the specific management required. It is clear that the protocol is not being followed at the Grange.*

'The documentation available at the Grange relating to Mark's needs was formulated by the Care Manager. However, the Grange lacks a detailed Care Plan for staff to use to care for Mark. From interviews with staff it was clear that they were not aware of Mark's specific needs, and had not received specific instruction on meeting his needs. In addition, whilst Care Management documentation was available, it is unclear how the home's management made use of the information so that staff could care for Mark.

'Induction procedures for new staff working at the Grange are poor, and result in critical procedures not being understood and followed. This occurred at the Grange in respect of: completion of incident forms; implementation of Risk Management guidelines to ensuring Mark's safety.

'Staff at the Grange believed the epilepsy mat used by Mark to be faulty. No action was taken between 17.6.03 and 26.6.03 to establish the reason for this, or to replace the equipment. No contact was made with specialist staff for advice.

'In summary, the care offered to Mark Cannon during his respite stay at the Grange from 17.6.03 to 27.6.03 was of a standard that does not meet the minimum requirements of the National Care Standards Commission

(NCSC). Whilst individual staff acted with best intent to meet Mark's individual needs, corporate failure ultimately lead to a failure to meet Mark's care needs during his stay. This failure may not have prevented Mark injuring himself during an accident, but may have contributed to his further distress and further aggravated his injury.'

181 The First Independent Investigator made a number of recommendations in her report to rectify the shortcomings she had identified. These recommendations included steps to improve the production of care plans for respite clients, ensuring effective management, staff training, induction, incident recording and risk assessment.

The Council's response and Mr Cannon's mother's further complaint

182 The documentary evidence does not clearly establish what happened once the report was received by the Learning Disability Service. The status of the report is also not clear as the letter sent to Mr Cannon's mother on 30 July 2003 by a customer services assistant seems to suggest that the report was an investigation into her complaint. However, that letter incorrectly describes the First Independent Investigator as the *'Learning Disabilities Team Manager'*. Moreover, in her interview (later in this report) the Learning Disability Service Manager stated that the First Independent Investigator's report was not an investigation into the complaint but, rather, an internal investigation for the benefit of the Learning Disability Service. A memorandum dated 5 February 2004 between the Council's Legal Services department and the Learning Disability Service Manager suggests that the status of the report was under discussion and that there were concerns about whether it was appropriate to disclose the report to the family given that Mr Cannon had died after the report was finished and that the first stage of the Council's complaints procedure did not appear to have been completed.

183 In early 2004 Mr Cannon's mother contacted the Learning Disability Service again and repeated her concerns about what had happened to her son. On 2 June 2004 she met the Learning Disability Service Manager and the Complaints Manager and again made a formal complaint regarding her son's care. On 11 June 2004 the Council's Complaints Manager wrote to Mr Cannon's mother informing her that:

> *'Further to the meeting of 2 June at the Hermitage with you and your husband, I have considered your complaint and will be taking this through the statutory complaints procedure.* [The Second Independent Investigator] *has been appointed as the independent investigating officer and I am meeting him on 17 June for a briefing. He will be contacting you week commencing the 21 June to clarify and confirm the details of your complaint.'*

The report of the Second Independent Investigator

184 Although it is not entirely clear from the available evidence, it would appear that a Second Independent Investigator was asked to carry out an investigation under Stage 2 of the complaints procedure. The Second Independent Investigator reviewed the case file and concluded that, before any further investigation took place, the outcome of the First Independent Investigator's report should be shared with Mr Cannon's family. This concluded the Second Independent Investigator's involvement and he did not carry out an investigation of his own and did not produce

a report. At this stage it would appear that Mr Cannon's father had again become involved in the complaint to the Council and records show that he contacted the Learning Disability Service by telephone. As a result, the Learning Disability Service Manager forwarded a copy of the First Independent Investigator's report to him on 17 August 2004. On 31 August 2004 the Council's Complaints Manager wrote to him separately, also enclosing a copy of the report and saying:

> *'I have been informed by the independent investigator* [the Second Independent Investigator] *that the* [First Independent Investigator's] *report forms the basis of an investigation. This report was completed by* [the First Independent Investigator] *on 18 September 2003 and therefore is timelier to the incident at the Grange during Mark's respite period. Would you please consider this report (I attach a copy) and advise me of what you would want an additional complaint investigation to establish.'*

Mr Cannon's father's response on behalf of the family

185 Mr Cannon's father responded by providing a lengthy document on behalf of the whole family, including Mr Cannon's mother. This set out their dissatisfaction with the report which they said did not go far enough to establish what had happened to Mark and who was to blame. They also expressed their concern about the serious shortcomings which the investigation, however inadequate, had clearly identified. In particular, the family expressed concern about:

- the failure of the investigation to identify the cause of Mr Cannon's injury;
- the failure to resolve the inconsistencies in the evidence given by staff at the Grange;
- the failure of staff to take action regarding the epilepsy mat;
- the failure to adequately monitor Mr Cannon despite his assessed care needs;
- the failure to adequately record Mr Cannon's earlier fall from bed and to take necessary precautions to prevent a recurrence;
- the failure to deal with Mr Cannon's injury safely, causing him further pain and injury; and
- the failure to ensure that adequately qualified and trained staff were on duty on the night of Mr Cannon's injury.

186 Mr Cannon's family expressed their unhappiness at the fact that the Council had put vulnerable people at risk because of the *'weak management'* in place at the Grange. They held the Council to blame for all the problems identified. The family concluded that the report raised more questions than it answered. They demanded that a further investigation take place so that the *'actual events and cause of Mark's severe injury'* could be established.

187 Meanwhile, it had been announced that a Coroner's inquest would be held on 28 October 2004 and Mr Cannon's father (with the support of Mencap) appointed solicitors to represent the family. They contacted the Council on 25 August 2004 requesting access to all records relating to Mr Cannon. As a result of these developments, the statutory complaints process, such as it had been, was once again suspended to await the outcome of the inquest.

188 The inquest opened on 28 October 2004 and adjourned on that day after hearing most of the evidence. It resumed and concluded on 17 January 2005. The Coroner concluded that she could not establish a direct causal link between Mr Cannon's care at the Grange and his subsequent death. But she found that Mr Cannon's death *'flowed from the consequences of the injury he sustained at the Grange'*. She issued a verdict which stated that he *'died as a result of an accident'*. She declined to add a finding that *'neglect'* had contributed to his death.

The Council's refusal to continue the complaints process

189 Following the conclusion of the inquest the Council's Complaints Manager wrote to Mr Cannon's mother on 29 March 2005 saying:

> *'I have reviewed your complaint file in the light of the outcome of the Coroner's inquest. It is the Council's view that all of the issues that you raised have been dealt with in a judicial context. The above report was reviewed by the Coroner during the inquest. Therefore it is no longer appropriate for the issues you raised to be addressed by the statutory complaints process within Havering.'*

190 In a letter dated 6 April 2005 Mr Cannon's mother responded to the Complaints Manager's letter and explained her unhappiness at the Council's decision not to investigate her complaint further. She also restated her unresolved concerns at length and insisted that her complaint be considered. She said:

> *'We feel we have the right to proceed to Stage 3 as we DO NOT accept your cold letter that it is no longer appropriate for our issues to be addressed by the statutory complaints process within Havering. What happened to Mark is extremely serious and we feel the Council is trying to hide behind a coroner's verdict. We WILL NOT allow our beloved son's accident to be swept under the carpet, his memory deserves more than that. You have a duty of care, we require this to be put into practice and insist you proceed with our complaint as we DO NOT accept your letter as closure.'*

191 In her response dated 12 April 2005 the Council's Complaints Manager said:

> *'I remain of the view that the Complaints Procedure is no longer appropriate. All of the issues that you raise were dealt with in the coroner's inquest and a judgement has been produced as a result of this inquest. The significant question that needed to be determined was the cause of Mark's death. The coroner found that Mark would not have died had he not sustained the fracture and because of that, a verdict of natural causes would not be appropriate. However, "accidental death" is a verdict used when an event occurs over which there is no human control or when there is no intended human act. There must be a clear causal link between the event and the subsequent death. The coroner found that Mark's death flowed from the consequences of the injury he sustained whilst in the Grange. This was therefore an appropriate verdict. The coroner was asked to consider whether it would be appropriate to add the words "to which neglect contributed". The coroner concluded that there was no evidence to support gross failures at any stage of Mark's care, and therefore there was no basis to add that clause.*

'I appreciate that these may be findings that do not provide a satisfactory conclusion as far as you are concerned. However, I cannot see what useful purpose is to be served by progressing the complaint to a Stage 3 Panel Hearing.'

Mr Cannon's mother's complaint to the Local Government Ombudsman and the Local Government Ombudsman's intervention

192 Mr Cannon's mother was not satisfied by the Council's response and on 10 May 2005 she made a complaint to the Local Government Ombudsman about the Council's refusal to continue the complaints process and asked him to intervene. The Local Government Ombudsman found that the Council's decision was unreasonable and questioned its interpretation of the outcome of the inquest. He said:

'The focus of the coroner's inquest was on establishing the cause of Mark Cannon's death. The inquiry would only have looked at the care he received while at the home in considering what part this played in his death. It was not its role to consider wider issues such as whether he had been provided with a reasonable standard of care, whether there had been fault by the Council in delivering this, what changes might be required to Council procedures as a result of identified faults and if any remedy for [Mr Cannon's mother] *might be appropriate.'*

193 He asked the Council to reconsider its decision and to allow the complaint to proceed through the normal complaints procedure. On 14 December 2005 the Council agreed to do this. On 23 January 2006 the Head of Adult Social Services wrote to Mr Cannon's mother to inform her that the Council had identified an investigator with suitable experience to carry out an investigation. The Third Independent Investigator delivered his report on 9 March 2006.

The report of the Third Independent Investigator

194 The Third Independent Investigator conducted his enquiries by means of a review of the relevant information and a number of telephone interviews. His report contained a number of inaccuracies which caused Mr Cannon's family to question the quality of the investigation. The date on which the injury occurred was incorrectly recorded on a number of occasions. The Third Independent Investigator's account also suggested that only Mr Cannon's father complained to the Council in July 2003 and that no further complaint was made until his mother wrote in July 2006. In fact, she also made a formal written complaint in July 2003 and numerous subsequent restatements of the complaint were made by the family in the intervening period. This is an important issue and is not acknowledged by the Third Independent Investigator who was also unclear about the status of the First Independent Investigator and describes her as the *'Community Disabilities Learning Team Manager'*. According to the Learning Disability Service Manager's statement quoted later in this report, the First Independent Investigator did not work for the Council. Indeed, had she been a manager in the Council's Learning Disability Service she could not be said to be independent. And if this reference is meant to indicate that she held her position in a neighbouring council, this was not made clear.

195 The Third Independent Investigator indicated that it was his role to investigate the complaint which had been made by Mr Cannon's mother to the Local Government Ombudsman, namely that:

'a) the Council did not provide an appropriate level of care to her son Mark during his stay at The Grange care home;

b) the Council had refused to allow her to progress to stage 3 of the statutory social services complaints procedure and

c) the Council has not acted in a compassionate manner towards her.'

196 He also noted that his investigation was being carried out under Stage 2 of the complaints procedure. There is nothing in the available evidence to indicate why the Third Independent Investigator was limited to investigating only the complaint put to the Local Government Ombudsman rather than the broader complaint which had already been put to the Council by both Mr Cannon's parents.

197 Having reviewed the documentary evidence, the Third Independent Investigator concluded that the First Independent Investigator's report dated 18 September 2003 was *'a significant document'* and he commented on his evaluation of this report. He said:

> *'There is every reason to conclude from the report that an impartial and thorough investigation was carried out.'*

But he agreed that:

> *' ... it does, however, leave a number of unanswered questions. These are catalogued in correspondence from both* [Mr Cannon's parents] *in formulating their complaints following Mark's death. ... They are questions to which answers can no longer be found.'*

He went on to say:

> *'The report does, however, clearly identify the areas of practice that fell below acceptable standards. It made recommendations for ways in which practice could be improved in order to minimise the likelihood of such events reoccurring.'*

198 The Third Independent Investigator also reviewed the way in which the Council had handled the family's complaints and identified the confusion regarding the status of different stages of the investigation including the obvious ambiguity about the role of the First Independent Investigator. He also addressed the Council's decision to terminate the complaints process following the Coroner's inquest and concluded that this had been unreasonable.

199 The Third Independent Investigator's conclusions and recommendations are set out at Annex B. In summary, he upheld the complaint about the level of care provided to Mr Cannon and partly upheld the complaints about the Council's management of the complaint and their manner towards Mr Cannon's mother. He recommended that: Mr Cannon's mother should be informed about changes in practice resulting from her complaint; actions should be taken to address shortcomings identified; a Stage 2 investigation should be carried out; and a meeting should be offered with a senior manager in Social Services.

The Council's response to the Third Independent Investigator's report

200 Having received the Third Independent Investigator's report, the Council followed a recognisable complaints process and, on 12 May 2006, the Head of Adult Social Services issued the first formal response to Mr Cannon's family in a letter to his mother. The Head of

Adult Social Services identified his response as being the outcome of Stage 2 of the complaints process. He began by providing the Council's response to the complaint that the Council had failed to provide an appropriate level of care to Mr Cannon during his stay at the Grange:

> *'As with the* [Third] *independent investigator, I uphold an element of this complaint as the report highlighted a number of issues in relation to shortcomings in practices and training. I would like to reassure you that procedures are in place ... following the recommendations of* [the First Independent Investigator]*'s report. This includes ongoing induction and training for staff to ensure that they understand care needs, understanding their responsibility in relation to epilepsy and that they receive the appropriate first aid training. Support plans are in place for each resident and there is continued partnership working with health professionals. I therefore uphold an element of this complaint as there were shortcomings in practices identified at this time, however there is no indication that Mark's fall was attributed to these shortcomings.'*

201 The Head of Adult Social Services also accepted in his response that there had been confusion over the progress of the complaint and attributed this to *'external investigation'* involving the police and the Coroner. He said Stage 2 had now been completed and Stage 3 was open to Mr Cannon's mother. He did not, however, accept that the Council had not acted in a compassionate manner and maintained that Social Services staff had provided significant support to the family. He did, however, accept that the problems the family had experienced in pursuing their complaint (which he described as a *'procedural element'*) may have caused them distress and *'could have been handled differently'*. Overall, the response was brief and did not fully accept any element of the complaint.

Mr Cannon's mother's response to the Third Independent Investigator's report and the Council's subsequent actions

202 Mr Cannon's mother responded on 13 June 2006, saying she had considered the Third Independent Investigator's report and the Head of Adult Social Services' letter but was not satisfied by the Council's response. She said that she wanted to proceed to Stage 3 of the complaints process. She set out the reasons for her unhappiness with the Head of Adult Social Services' response. She said:

> *'I don't agree with the view of* [the Head of Adult Social Services] *that Mark's fall was not attributed to the shortcomings of practices by the staff on duty the night of the accident.'*

She then restated her specific complaints which she said had not been addressed. These included the failure to use the epilepsy mat and the failure to supervise Mr Cannon for long periods during the night.

203 Mr Cannon's mother asked for her complaint to proceed to Stage 3 and completed the relevant form which was dated 16 July 2006. The Council acknowledged her request and informed her that Stage 3 would involve a Hearings Panel which would be chaired by an independent person who would *'hear and review the case'*. The letter indicated that only one aspect of the complaint (at Mr Cannon's mother's request) would be the subject of the Stage 3 complaint. This was:

'That the council did not provide an appropriate level of care to your son Mark during his stay at the Grange care home. You do not agree with the adjudication of this point of the complaint and feel that Mark's fall was attributable to the shortcomings of practices by the staff on duty the night of Mark's accident, for the reasons outlined within your letter dated 13 June 2006.'

Stage 3 of the Council's complaints procedure: the Review Panel hearing

204 The Review Panel hearing took place on 23 August 2006. The Review Panel consisted of an independent lay chairman and two councillors. The Head of Adult Social Services, a complaints officer, a legal adviser and a committee officer were also in attendance. The minutes of the Review Panel meeting record that Mr Cannon's mother addressed the panel and set out her concerns again in detail.

205 The minutes also show that the *'head of service'* (presumably the Head of Adult Social Services) had responded to the questions Mr Cannon's mother had put to the panel by saying he accepted that the staff at the Grange were *'not familiar'* with the process they had to undertake. He also apologised for the wording of the letter (discontinuing the complaint process) that the family had received. He emphasised again that Social Services staff, on an individual basis, had continued to maintain contact with the family to support them following Mr Cannon's injury and subsequent death. In defence of the Council's actions following the injury, he said that it was the service itself that had triggered the investigation (presumably the First Independent Investigator's report). He said that service delivery at the Grange had been *'revamped'* and that the Council had *'acted on the* [First] *independent investigator's report'*.

206 The minutes also record that the *'head of service'* had provided the Review Panel with the Council's formal response to the complaint. He said that Social Services had *'taken on board and implemented'* a number of recommendations arising from Mr Cannon's mother's complaint:

'• *The Council had appointed a full time manager at the Grange.*

- *Following an unannounced inspection, the Avenues Trust had been removed from delivery of services at the centre.*

- *There was now in place ongoing induction and training for all staff in order that the importance of implementing agreed policies, procedures and protocols, could be made clear.*

- *The service had now put in place a process to ensure that all staff were aware of their responsibilities to understand the care needs and risk management guidelines of all residents.*

- *A process was now in place and training was ongoing to ensure that proper recording of all incidents did take place. The incident process report goes directly to the head of Adult Social Services.*

- *Training was in place and staff were made aware of their responsibilities for recording and understanding residents' needs. The head of service added that responsibility for this procedure was now under the remit of Adult Social Services.*

- *Support plans for all residents were now in place and available on the premises.*

- *A detailed training programme for all staff as part of their personal development plan was now operational.'*

207 The minutes continued:

> *'The head of service added that the service had appointed someone to ensure procedures were in place and implemented. The care Mark received should have been better and the wording of an earlier letter sent to the family was not helpful to the situation. The head of service clarified that not every serious incident reached the trigger point to get the police involved. The current policy was still in draft at that time but even now Mark's accident would not have reached the level to trigger involving the police.'*

208 In response to Mr Cannon's mother's view that her son had been neglected the head of service responded that he:

> *' ... would not use the word neglect but did accept that there was poor care practice. He also accepted that there must have been a shortfall of staff for a two hour monitoring absence to occur.'*

209 The Review Panel's decision was recorded in the minutes as follows:

> *'Following careful consideration of the representation the Panel had no hesitation in upholding the complaint which was admitted to, by the service. The Panel strongly sympathised with* [Mr Cannon's parents and Mr Handley] *in respect of the whole issue and listened most carefully to their representations on the standard of care that Mark received at his last stay at the Grange. The Panel agreed with the appellants and the service's view that the standard of care Mark received fell below what he should have been given.*
>
> *'The Panel was pleased to note that the service had accepted and implemented the recommendations made in the report of the independent investigators –* [the First Independent Investigator] *and* [the Second Independent Investigator] *– and that substantial changes had been made to the running of the Grange and the training of staff. The Panel was also pleased to note that the family had received support from staff at St Bernard's.'*

210 The Review Panel's decision concluded with a single recommendation to the Council which was to *'arrange for* [Mr Cannon's mother] *to receive an appropriate amount for the inconvenience of having to go through this complaint process'*. Documentary evidence shows that the minutes of the Review Panel hearing were not sent to Mr Cannon's mother until 31 January 2007. No explanation for this delay has been established. The Council's Committee Officer did, however, write to her on the day of the hearing (23 August 2006) informing her, briefly, of the outcome and telling her what would happen next:

> *'Following careful consideration of the representation made by you and* [Mr Cannon's father] *the Panel decided to uphold your complaint. The Panel sympathises with you and* [Mr Cannon's father] *in respect of the whole issue. The Panel was pleased to note that the service has accepted and has implemented the recommendations made in* [the First Independent Investigator] *and* [the Second Independent Investigator]*'s report.*

'The legislation under which the Panel met requires that they make recommendations ... as to the steps to be taken to deal with the issues raised. Accordingly the Panel have recommended that the Group Director for Sustainable Communities arrange for you to [be] *compensated with a sum of £250 for having the inconvenience of having to go through this complaint process. You will hear in due course from the Director in that respect.*

'More detailed notes of the decision, outlining the facts and reasons taken into account, will be sent to you within 28 days, as will information relating to the Local Government Ombudsman.'

211 It is not clear how the amount of £250 was determined as this was not referred to in the minutes of the Review Panel hearing, and is not referred to elsewhere in the documentary evidence. There is also no evidence to show that the more detailed explanation of the decision was sent within 28 days. Indeed, the only record Mr Cannon's mother received regarding the Review Panel hearing and its outcome was a letter from the Committee Officer dated 31 January 2007 enclosing a copy of the minutes which, it was suggested, *'set out in full the Panel's decision, outlining the facts and reasons taken into account'*. The letter also made clear that *'This completes the Council's consideration of the appeal'*. A leaflet setting out how to complain to the Local Government Ombudsman was enclosed.

212 Meanwhile, on 18 September 2006, in response to the Review Panel hearing findings and recommendations, the Council's Group Director, Sustainable Communities, wrote a short letter to Mr Cannon's mother to set out his *'decision'*. He said:

'In considering the Panel's recommendations for compensation, I agree that an ex-gratia payment of £250 would reflect the delays and effort that you have had to expend. I hope that you now feel that the service has taken on board the issues raised by this complaint. I understand this has been difficult for you, but hope you and your family are confident of the positive changes made by the service. I trust that this now resolves the points in your complaint to your satisfaction. If you still remain dissatisfied, you may contact the Local Government Ombudsman ... '

Mr Cannon's mother's response to the outcome of the Review Panel hearing

213 Mr Cannon's mother responded to the Group Director's letter on 21 January 2007 expressing her unhappiness at the Council's response to the Review Panel's findings and complaining that she had not received the further explanation promised by the Committee Officer on 23 August 2006. The Group Director wrote to her on 26 January 2007 saying:

'I have reviewed the case and the offer we have made to you and believe that it is a fair reflection of recompense for the issues that the hearing found in your favour. I realise how emotional the whole subject of Mark's death will always be for you and how you may not feel that you and your family have been treated fairly, but I believe that the offer we have made is comparable to other cases. You may wish to continue your complaint to the Ombudsman but this may not result in any changes to the proposal we have made. All our staff feel for your loss acutely but we are not able to change our offer of compensation.'

214 Mr Cannon's mother wrote a final letter to the Group Director on 5 June 2007 saying that she would accept the sum of £250 for *'inconvenience and delay'* but that in all other respects she remained dissatisfied and that she would, with the help of Mencap, be taking her complaint further. On 14 June 2007 the complaints process came to an end with a letter from the Group Director which said:

> *'I recognise that this has been a difficult process for you, but I need to clarify that although* [the First Independent Investigator]*'s report indicated corporate failure in relation to meeting your late son's care needs, it does not state that your son's accident was caused by "corporate negligence" and this was also reaffirmed in* [the Second Independent Investigator]*'s report. I have requested that a cheque be raised for £250 and sent to you within 14 days. Please be advised that your complaint will now be closed as the statutory complaints process has now been exhausted.'*

215 Mr Cannon's mother subsequently complained to the Health Service Ombudsman and me asking us to carry out a joint investigation into the care provided by the Council and, subsequently, by the NHS.

216 The Council has accepted that the complaints could have been handled in a better way. But it argues that it was not responsible for all the delays and has referred to a number of the complexities involved. They include:

- The complaint starting before Mr Cannon's death and then the incident being subject to police investigation as part of the overall inquiry into his death.
- Two separate complaints being made by two estranged parents.
- A complex Coroner's inquest and its impact on the complaints process.
- An implied threat of legal action and possible compensation.
- Different personnel within the Council handling the complaints.
- The Second Independent Investigator failing to investigate properly.
- The legal ramifications of Mr Cannon's death on the complaints process.

The relationship between the Council and the Avenues Trust

217 I have set out the relationship between the Council and the Avenues Trust in paragraphs 154-159 above. The Avenues Trust's stated aims included:

- Support service users to undergo an individual transition plan to minimise any distress that time away from their normal home may cause. This is done through liaising with the multidisciplinary team.
- To keep carers fully informed of the service through regular meetings and to incorporate their views in service provision.
- Provide support to the service user as identified by the care management assessment.
- To continue to adhere to any intervention plans relating to behaviour or self help skills during their stay.

- Ensure staff support is adequate in numbers and appropriately skilled to meet the needs of the respite users.

218 Various contract monitoring meetings between the Council and representatives of the Trust were held through 2002 and one in May 2003. Provision of respite care was specifically considered at the meeting in July 2002 and following this a pre-admission assessment form was drawn up. The Council considers that this effectively acted as a Provider Care Plan. At the meeting in May 2003 it was recorded that the manager was to carry out risk assessments for respite customers on their next visits. Despite this, the form was not completed for Mr Cannon's stay in June 2003. The Council considers that it had done all it reasonably could to ensure that the Avenues Trust had in place the appropriate procedures.

Statements and interviews: the Learning Disability Service Manager and the Complaints Manager at the time

219 Further information was provided to my investigator through a written statement made on behalf of the Learning Disability Service and during an interview with the Learning Disability Service Manager and the Complaints Manager at the time of the events. The Learning Disability Service Manager said that she had been involved in the management of the Grange for some time and, in May 2003, she had taken over line management responsibility for the Grange. The Council states that the Learning Disability Service Manager had a *'contract monitoring role'* rather than *'line management responsibility'*.

220 The Learning Disability Service Manager clarified staffing arrangements at the Grange at the time of the interview. She said a number of agency staff were employed at the Grange but that these were not temporary or short-term staff employed on a shift-by-shift basis. These were long-serving, highly experienced staff, many of whom had been at the Grange for many years. The high number of agency staff reflected the fact that the facility was due for closure and permanent posts could not be filled as it was known that some posts would not be required when the new facility opened. The use of agency staff did not reflect staffing problems at the Grange. The Learning Disability Service was also asked to clarify the status of the staff on duty on the night of Mr Cannon's injury. It said that the First Care Worker was an agency employee and had worked at the Grange for about a year. The Second Care Worker was a Council employee (residential night care officer) and had joined on 9 May 1993. The Third Care Worker was a permanent employee of the Council until 29 June 2002 when she retired but was then employed at the Grange on a part-time basis through a specialist care agency. She was a night care officer. The Officer sleeping-in was also a Council employee.

221 The Learning Disability Service Manager was asked whether it was possible for staff undertaking duties in the Day Centre or the kitchen to carry out monitoring or supervision of clients in the Darby Unit. She responded that this was not possible as the Day Centre and the kitchen at the Grange were not within earshot or sight of the Darby Unit.

222 The Learning Disability Service Manager also said that she was satisfied that the Learning Disability Service had done as much as it could to support Mr Cannon's family immediately after the accident. A member of staff from the Grange had travelled with Mr Cannon to the hospital and stayed with him until family members arrived. The Manager of the Day Centre, St Bernard's, spent most of the following day at the hospital and visited every day during the first admission.

223 With regard to action taken subsequent to Mr Cannon's injury, the written statement said:

'The Head of Service, and [the Learning Disability Service Manager] *decided it would be advisable to bring the management of the Grange back in-house, consequently the Avenues Trust contract was withdrawn effective from December 2003. During the immediate nine months after the incident,* [the Learning Disability Service Manager] *was extensively involved in overseeing management practice at the Grange. This included close contact with all residents.*

'The new Manager was supported by the CLDS [the Community Learning Disability Service] *Resource Manager and* [the Learning Disability Service Manager]. *All training, standards, and procedures which had been in place were reviewed and their enforcement was assured by the Resource Manager. The procedures included:*

- *Personal Development and Performance Appraisals (PDPAs)*
- *Incident reporting*
- *Risk assessments*
- *Staff meetings*
- *Staff NVQ training*
- *Various mandatory LBH training e.g. Health and Safety, Appraisal Care Planning*
- *Epilepsy and medication administration*
- *First Aid*
- *Regular supervision for the manager.*

'Incident recording has been strictly adhered to, the incident recording process has been mandatory training for managers and others working within [the Council]. *According to the nature of an incident a Protection of Vulnerable Adults (POVA) investigation could be instigated. Such investigations include the attendance of a wide variety of professionals including external agencies and the police. There is a dedicated team in Adult Social Services to the POVA process and training is mandatory for staff working with vulnerable adults. Such training courses are run regularly and are always fully booked.* [The Council] *also extend this training to the voluntary and private and independent sectors.*

'Epilepsy training is regularly conducted by the CLDS's nurses. This training was documented in the supervision notes of the manager and seniors at the Grange.

'The Resource Manager ensured that the new manager was well supported and the multidisciplinary team were regularly involved in training and care standards at the Grange. Care plans were in place and recorded on client files and were live working documents at the Grange.'

224 The Complaints Manager said she now accepted that her decision to write to Mr Cannon's mother on 12 April 2005 saying the complaint would now be closed had been wrong. She could also see that the wording of her letter may well have caused considerable upset. The Complaints Manager said that she felt that in writing the letter she had made a mistake and, with the benefit of hindsight, she would not have written the letter in the way she did. She could now see the letter was insensitive and she took responsibility for the hurt this had caused.

225 Finally, the Learning Disability Service Manager and the Complaints Manager both said they felt extremely sad about what had happened to Mr Cannon and the obvious distress which the family were still clearly suffering. They said they hoped that this investigation would help to lay their concerns to rest and allow them to move on from this very difficult period. The Complaints Manager said she wanted to express again her regret at the distress caused by her actions and she could well imagine how Mr Cannon's mother must have felt when she received her letter.

Changes in respite care provision

226 The Council has stated that lessons have been learnt and steps taken to prevent a reocurrence of shortcomings identified at the Grange. In order to establish the extent to which these assurances were supported by evidence, further enquiries were conducted and relevant documentary evidence obtained.

227 There was an unannounced inspection of the Grange by the Commission for Social Care Inspection in September 2006. This said:

> *'Respite stays are usually planned. However in an emergency the home will take people for respite stays. The file of one of the respite residents was seen at the time of the inspection and this contained information to enable staff to meet this person's needs ...*
>
> *'Residents' plans contain updated information about their needs and therefore residents' current needs can be met.*
>
> *'Risk assessments are comprehensive and reviewed regularly and therefore residents are supported to take risks according to their needs.*
>
> *'Evidence*
>
> *'All of the residents have a care plan. Care plans seemed comprehensive and contained appropriate detailed information. There was clear information on individuals' likes, dislikes, routines and needs. Details on individuals' religious and cultural needs were also in their plans. The information in the plans seen reflected individual needs and showed the permanent staff know the residents well. All of the care plans have been updated as required by the previous inspection. More than half of the residents have had reviews and others are booked in the near future.'*

228 There was a further unannounced inspection by the Commission for Social Care Inspection in January 2007 which reported:

> *'A new resident has recently moved to the Grange in preparation for his move to the new supported living scheme. The paperwork with regard to this individual was examined. This contained an assessment profile and a care plan ...*
>
> *'The file of one of the respite residents was seen at the time of the inspection and this contained information to enable the staff to meet the person's needs.*
>
> *'Residents' plans contain updated information about their needs therefore residents' current needs can be met.*
>
> *'Risk assessments are comprehensive and reviewed regularly and therefore residents are supported to take risks according to their needs.*

'Evidence

'All of the residents have a care plan. Care plans seen were comprehensive and contained appropriate detailed information. There was clear information on individuals' likes, dislikes, routines and needs. Details of individuals' religious and cultural needs were also in their plans ... there was also evidence that care plans are reviewed internally every four to six weeks to ensure that they are up to date. All of the care plans seen were up to date.

'The requirement from the previous inspection that care plans must be reviewed with the resident and significant others at least every six months and updated to reflect changing needs has not yet been fully met, but as significant progress has been made the timetable for completion has been extended to allow for the remainder of the reviews to take place.

'There are risk assessments in place. These identify risks for the residents and indicate ways in which the risk can be reduced to enable the residents' needs to be met as safely as possible. For example, the support a resident needs to bathe or when in the kitchen. The risk assessments have been reviewed and were up to date and are relevant to individuals.'

229 The Grange was closed in May 2007 and replaced by several new respite care facilities. The Council's Learning Disability Service Manager confirmed that a client such as Mr Cannon would now be placed at 'Neave Crescent 74' for respite care, although there were other facilities which could also be used. A copy of the Commission for Social Care Inspection (replaced the National Care Standards Commission in April 2004) report for this facility dated 13 November 2007 was obtained to determine whether effective action had been taken in the light of the findings set out in the investigation reports. One of the key criticisms had been the failure to produce a regularly updated provider care plan to ensure that staff were aware of individual needs.

230 For the most part, the Commision for Social Care Inspection report is positive and commends the *'competent and qualified staff who were well supported and supervised'*. The quality of the home's management in particular was praised. However, there were a number of areas where the report suggested improvements could be made in respect of respite care and, in particular, care planning:

> *'What they could do better: All care plans and risk assessments need to be up to date so that the staff team know about service users' needs and likes and how to safely meet these.*
>
> *'More work is needed in the respite unit on service users' needs and likes so that it is as well run, and that information is as good as, in the residential unit.*
>
> *'For permanent service users, care plans and risk assessments contain sufficient information to enable staff to safely meet their needs. They are consulted about what happens in the home as far as they are able and their opinions are welcomed and respected. However information about respite service users is not always up to date and this can potentially place service users at risk.*

'Respite Service users. ... The care plans for two people who have recently used the service were examined. Both individuals [had] *complex needs but in both cases information had not been reviewed or made up to date. Therefore staff* [did] *not necessarily have information about individual needs.*

'It is particularly important for people who are receiving respite care that information is kept up to date, as their needs and risks may change between visits. Several of the staff team worked at the service that closed [the Grange] *and do know the service users and feedback about the quality of care was positive. However there have been three incidents that have been investigated under the Council Safeguarding Adults procedure and all of these were in relation to respite service users. It is possible that if assessments, care plans and risks had been updated some of these problems may not have arisen.'*

231 The report made a number of recommendations to establish *'good practice'* in line with national minimum standards. However, the report indicated two *'statutory requirements'* which *'must be taken so that the registered person/s meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The Registered provider(s) must comply with the given timescales* [31 January 2008]'. The two requirements were:

'1. Care plans must be reviewed regularly and updated as necessary, including people receiving respite care.

'2. All risk assessments must be reviewed regularly and updated as necessary, including people receiving respite care.'

The police investigation and the Coroner's inquest

232 Two post mortems were carried out following Mr Cannon's death. One was ordered by the Coroner and the other was arranged at the request of the police. An overview report was later produced by a forensic pathologist. Information relating to these examinations and subsequent proceedings is recorded here only so far as it provides information about the cause of Mr Cannon's death and the nature of the injury he sustained. This information relates to both the complaint against the Council and the complaint regarding Mr Cannon's subsequent care.

233 The Coroner ordered a post mortem which was carried out on 1 September 2003. The pathologist who carried out the examination (the First Pathologist) concluded:

'In my opinion, death was due to natural causes and was a result of bronchopneumonia. There was considerable oedema of the body which affected the soft tissues and skin with pleural and pericardial effusions and ascities (fluid in the cavities around the abdomen) present. This oedema was consistent with either renal failure or multiple organ failure. Fracture of the left femur had recently occurred.

'CONCLUSIONS AND CAUSE OF DEATH

'I. disease & condition directly leading to death (a) Bronchopneumonia.

II. Unrelated (contributory) Fracture left femur.'

234 On 2 September 2003 a Home Office Pathologist (the Second Pathologist) conducted a second post mortem. He concluded Mr Cannon probably had weakened bones due to his immobility and his injury was possibly the result of a fall. He recorded the cause of death as:

'1a Bronchopneumonia, 1b Perinatal hypoxic brain injury.'

235 The police conducted an investigation into the circumstances of Mr Cannon's injury and subsequent death. They asked a forensic pathologist (the Third Pathologist) to produce a medical report about Mr Cannon's death. In his report, dated 25 January 2004, the Third Pathologist provided the following opinion:

'Mark Cannon sustained a fracture of the upper part of the left femur. This is consistent with him having fallen. It is not a type of fracture that is commonly associated with being caused by an assault.'

236 Following receipt of the report, the police discontinued their enquiries. The inquest was opened on 28 October 2004 but adjourned after hearing evidence from Mr Cannon's parents, the police, medical and nursing staff from the Trust, care home staff from the Grange and the First Pathologist. The hearing continued on 17 January 2005 and evidence was taken from further witnesses, including medical staff.

237 At the inquest a consultant employed by the Trust gave evidence that *'in his opinion* [Mr Cannon] *would not have been able to weight bear and walk back to bed as described by* [the First Care Worker] *if he had sustained his fracture* [between 9.30pm and 10.00pm]'. But, he *'speculated that* [Mr Cannon] *could have scrambled back into bed after a fall that caused a fracture because the pain threshold can be altered for some time after a fit,* [the] *so called post-dicteric phase which could last in his opinion he thought up to thirty minutes after a fit'*.

238 In her summing up the Coroner emphasised that her remit was to establish the cause of Mr Cannon's death taking into account only '*direct, causal factors*'. On this basis she concluded Mr Cannon had *'died as a result of an accident'*.

239 Having examined events on the night of Mr Cannon's accident, the Coroner concluded that:

'Having considered the matter very carefully, I consider that appropriate care was taken of Mark during his stay at The Grange.'

She considered there had been no *'gross failure to supervise Mark in The Grange in view of his known tendency to fit'*. She also found as a fact that:

'... on the balance of probabilities Mark would not have died when he did and from the cause given had he not sustained the fracture ... It is clear to me that Mark's death has flowed from the consequences of the injury he sustained in The Grange.'

My approach to my findings

240 The incident in which Mr Cannon sustained his injury occurred on 26 June 2003. Since the incident there have been a number of investigations carried out and an inquest held in which those most closely involved in the incident have given evidence. In carrying out my investigation and in reaching my conclusions,

having regard to the passage of time since the incident, and to the likelihood of those giving evidence inadvertently confusing actual events with information disclosed in the course of the subsequent investigations and inquest, I have given greater weight to the contemporaneous evidence of relevant personnel so far as that is available.

241 The Council is critical of this approach and states that it *'does not accept the facts set out* [in the draft of this report] *as either accurate or reasonable'*. The Council has provided to me a copy of a recent exchange of emails with the Third Care Worker in which the Council put questions to the Third Care Worker and invited her response. In responding, the Third Care Worker prefaced her reply by stating *'I will answer your questions as best I can but it was over* [five] *years ago and my memory is not as good as it was'*. This strengthens my view that, in considering and reaching conclusions on this complaint, I should give greater weight to the available contemporaneous evidence.

242 The Council has also questioned the standard of proof applied by me. In reaching decisions on the complaint I have adopted the standard of the balance of probabilities while bearing in mind that the more serious the allegation made, the more cogent the evidence that is required to overcome the inherent unlikelihood of what is alleged.

The actions of the Council: the Local Government Ombudsman's findings

243 Mr Cannon's family have found it difficult to comprehend the conclusions reached by the First Independent Investigator. She made numerous criticisms of the management and staff at the home who she said did not deliver the standard of care that Mr Cannon required. Close supervision was the most important need that he had and this had been clearly identified in the past. Supervision was almost entirely lacking on the night of the injury. Despite these findings, the First Independent Investigator did not make any connection at all between these failings and the injury which Mr Cannon sustained. Having considered the evidence I have concluded that there were indeed significant failings in the care provided to Mr Cannon at the Grange which were the result of poor management, poor staffing arrangements, and poor care planning for respite clients. I describe my findings below.

Council's responsibility to ensure Mr Cannon received appropriate care

244 The Council argues that it was the responsibility of its contractors (the Avenues Trust) to ensure that its contract requirements were effectively met and, in commenting on a draft of this report, it has said that I have no jurisdiction to investigate the alleged maladministration of a party who is discharging an administrative function of the Council as the result of a contractual obligation. I note, however, that on three occasions the Council referred Mr Cannon's mother to the Local Government Ombudsman if she remained dissatisfied with the outcome of her complaints to the Council. It is not to the Council's credit that, having advised Mr Cannon's mother to take her complaint to the Local Government Ombudsman, it now says I have no jurisdiction in respect of her complaint. I am satisfied that I do have jurisdiction.

245 I consider that I am entitled to take into account the management arrangements at the Grange as set out earlier in this report, including that the Grange was owned and provided by the Council and that with the exception of the Registered Manager (in attendance only up to two-and-a-half days each week) it was staffed entirely by staff employed by the Council or by agency staff engaged by the Council. The reality was that, subject to the limited involvement of the Registered Manager, the home was run, and care was provided, by Council employees and Council engaged agency staff. The Deputy Manager was a Council employee who had responsibility for the operational running of the Grange and overall responsibility when the Registered Manager was not in attendance. On the night in question the only staff on duty were staff employed or engaged by the Council. In those circumstances, I have concluded that the acts and omissions to which the complaint relates were carried out by or on behalf of the Council, which must, in my view, accept responsibility for the failures I have found.

246 It is, moreover, the case that the Council was under a duty to take all reasonable steps to secure that there was at all times an adequate system for monitoring its contractor's performance. As Moses J, as he then was, put in *R v Servite Houses ex p Goldsmith* [2001] LGR55: '[the Council's] *duties to meet the assessed needs of the applicants do not cease once it has discharged its duty under section 21 by making arrangements with Servite. It remains under a duty to see that the applicants' needs are met and if necessary to re-assess them. It remains under an obligation to ensure that the arrangements which it has made continue to be sufficient to meet the needs of those qualified for such community care provision*'.

247 The Council was therefore under an obligation to put in place adequate arrangements for the discharge of its section 21 (*National Assistance Act 1948*) duties and under a continuing obligation to ensure that the arrangements which it had made were sufficient to meet the needs of Mr Cannon (and others) while resident at the Grange. I have considered whether the Council discharged its obligations towards Mr Cannon in a satisfactory manner.

248 In my view, the Council failed to take adequate steps to discharge those obligations. That is apparent from the conclusions of the First Independent Investigator whose recommendations were accepted by the Council. Having carried out my own independent consideration, I agree with those conclusions. That failure by the Council contributed to the serious failings in the standard of care provided for Mr Cannon at the Grange.

Lack of a provider care plan

249 When Mr Cannon's mother and her husband placed her son at the Grange on 17 June 2003, they did so on the understanding that his complex needs were recorded and understood and that they would be properly catered for by staff at the Grange. To ensure this happened certain administrative requirements had to be in place so staff had all the information necessary to care for his needs.

250 Some information was available to staff at the Grange. The Care Assessment of 2002 and the Care Plan based on it were on the Grange's files and so was a risk assessment carried out at the Grange in May 2001. By the time of Mr Cannon's stay at the Grange in June 2003, that risk assessment was over two years out of date. It still contained some relevant information. But, crucially, there was no Provider Care Plan for

June 2003 – or, alternatively, any statement that previous documentation available in respect of Mr Cannon's care needs had been reviewed and considered still to be appropriate – and no up-to-date risk assessment produced to detail how staff at the Grange would accommodate Mr Cannon's assessed needs, and just what steps they would take to prevent him from coming to harm during his stay. As is recorded above (paragraph 230) '*It is particularly important for people who are receiving respite care that information is kept up to date, as their needs and risks may change between visits*'. It seems to me both these documents were required to comply with national minimum standards. The failure by the Council to ensure that they were in place in respect of Mr Cannon, who was receiving respite care commissioned by the Council, was **maladministration**. I moreover, agree with the findings of the First Independent Investigator, who concluded from interviews with staff at the Grange '*that they were not aware of Mark's specific needs, and had not received instruction on meeting his needs*'.

251 These failures also represented a failure by the Council to make reasonable adjustments to meet Mr Cannon's needs and resulted in him being treated less favourably for reasons related to his learning disability.

Failings in the provision of care

252 I refer above (paragraph 180) to the finding by the First Independent Investigator, with which I agree, that:

> '*The fact that the homes manager is not available for half of the week* [in fact, the Manager was only available at the Grange for up to two-and-a-half days per week] *leaves the service with weak management, and a lack of monitoring/management supervision.*'

253 The First Independent Investigator was also critical, among other things, of the arrangements in place for staff training, record keeping, documentation in respect of care needs and completion of incident forms. She found, for example '*that staff at the Grange did not have records relating to the presentation of Mark's epilepsy or detailed guidance on the specific management required*'. Further, the protocol relating to risk management was '*not being followed at the Grange*'. Induction procedures for new staff were said to be '*poor and* [to] *result in critical procedures* [including implementation of risk management guidelines] *not being understood and followed*'. I agree with these criticisms.

254 I consider that the Council failed to secure that adequate arrangements were in place for the care of Mr Cannon at the Grange. That failure contributed to the serious failings in the standard of care provided for him at the Grange which the First Independent Investigator rightly found '*was of a standard that does not meet the minimum requirements of the National Care Standards Commission (NCSC)*'. The Council has accepted that the standard of care Mr Cannon received fell below that which he should have been given.

255 The First Independent Investigator went on to find that it was a '*corporate failure* [which] *ultimately* [led] *to a failure to meet Mark's care needs during his stay*'. In my view the Council was under a duty to see that Mr Cannon's needs were met but failed to do so. The Council failed to put in place adequate arrangements for the care of Mr Cannon and failed in its continuing obligation to ensure that the arrangements which it had made were sufficient to meet his needs. That was **maladministration** on the part of the Council.

256 I note, too, that the Council has previously acknowledged its failures here. The Council's Stage 3 complaints procedure upheld Mr Cannon's mother's complaint that *'the Council did not provide an appropriate level of care to (her) son'* and the Review Panel's decision records that the complaint was *'admitted by the service'*. And the Council introduced changes to its procedure and practices concerning care home placements, both in respect of the Grange and more generally in order to prevent recurrence of the failings which had been identified.

257 The Council has argued in commenting on a draft of this report that Mr Cannon can only have fractured his femur when the care worker was stationed outside his room. So, regardless of any possible shortcomings in the level of care and supervision provided earlier in the night, at the crucial point appropriate care and supervision was in place.

258 The Council suggests that Mr Cannon could have fallen and fractured his femur without the care worker (who the Council says was sitting outside his door) hearing the fall, and then managed to put himself back to bed. This seems to me to run counter to the argument the Council has advanced that Mr Cannon could not have broken his leg when the First Care Worker found him at around 10.00pm because he could not have walked back to his bed, while holding the hand of the First Care Worker, if he had a broken femur. But there is evidence that on the earlier occasion Mr Cannon had probably had a seizure as he was incontinent. In this post-seizure state he may well not have registered pain normally and so it is possible that he was able to be assisted back to bed, as reported by the First Care Worker. A consultant employed by the Trust gave evidence at the inquest that *'the pain threshold can be altered for some time after a fit,* [the] *so called post-dicteric phase, which could last in his opinion he thought up to thirty minutes after a fit'*. The Registered Manager, who carried out an investigation immediately after Mr Cannon suffered his broken femur concluded that *'The most likely explanation is that* [Mr Cannon] *had a seizure earlier in the night and was found by the* [First Care Worker] *soon after. The fact that* [Mr Cannon] *was incontinent when she found him would suggest this. Mr Cannon is thin and frail and could easily damage himself during a seizure. However* [the First Care Worker] *states that he walked back to bed 5 feet away with very little support which with a broken hip* [sic] *would be difficult. She does state that he walked slowly. The lack of reaction to the broken hip* [sic] *could be due to* [Mr Cannon] *being in recovery from seizure'*.

259 The suggestion by the Council that Mr Cannon may have fallen out of bed or have got out of bed and fallen over and broken his femur at around shortly before 3.15am and (despite not being in a post-seizure state) climbed back into bed unassisted appears to me to be the least likely explanation, especially as, when seen by the Third Care Worker at approximately 3.15am, Mr Cannon's bedding was undisturbed.

260 I do not consider it is possible to say with any reasonable certainty when the incident happened. The Coroner did *'not think* [Mr Cannon] *sustained* [his injury] *when he had his fit and was found by* [the First Care Worker]'. The First Independent Investigator concluded that it was likely to have happened at any point between 9.30pm and before 3.00am. The Council has previously accepted the finding of that Investigator's report. In my view the injury to Mr Cannon could have been sustained at any time from 9.30pm up to 3.30am.

261 But, regardless of when the incident happened, I consider that there was not on that night an appropriate level of care and supervision provided to Mr Cannon by the staff of Council employees and Council engaged agency workers. There was a chance encounter with the First Care Worker shortly after Mr Cannon had gone to bed and according to the Council a check on him probably some time after midnight. A care worker did not take up a position near to his room until 2.00am. Accordingly, I find that there was inadequate supervision of Mr Cannon between 9.30pm and 2.00am and that the Council did not meet its obligations to ensure that the care received by Mr Cannon sufficed to meet his needs. This was **maladministration** by the Council.

Failure to maintain Mr Cannon's safety by using the epilepsy alarm

262 Mr Cannon's mother and stepfather brought his epilepsy alarm with him. They fitted it themselves to his bed and ensured that it was working. They explained to staff how the alarm worked and left information about who should be contacted in the event that the alarm failed to work. The alarm was very sensitive and would have alerted staff to movements while Mr Cannon was in bed, such as those relating to an epileptic seizure, or movements prior to falling out of bed. The alarm was not in use on the night of the injury and it has been suggested by care home staff that the alarm was not working properly.

263 In commenting on the draft of this report the Council has also suggested that there may have been particular problems on Darby Unit which meant that the mat did not work. Mr Cannon's mother felt that the mat may have been removed by staff at the Grange because it would sound frequently as it monitored movement in bed by Mr Cannon. The Coroner said *'It appears that the mattress alarm was taken to the Grange, but it either didn't function or else it sounded so frequently that it was not in use at the home'.* But, regardless of the cause, there is no doubt that the alarm was not in use and that no attempt had been made to contact anyone who could have restored it to its proper use if it had been malfunctioning. Subsequent examination of the alarm suggests that it was in full working order.

264 Care home staff failed to ensure that an important piece of safety equipment was in use and this added to Mr Cannon's risk of serious harm. I note that the Council accepts that this was a *'shortcoming'* but appears to have misunderstood the use of the mat asserting that its function was to *'sound an alarm in the event that a person fell down onto it'*. That is incorrect. The mat was for use as a fixture to the mattress of the bed to detect movements by the person when in bed. I further note the view of the Registered Manager of the Grange, expressed shortly after the incident and before there was any question raised about the epilepsy mat provided by Mr Cannon's mother, that *'The use of alarm mats needs to be considered for respite care users such as a mat fitted next to a bed would be set off when a service user places their foot on it and also alerting night staff. The use of similar devices attached to beds, sensory lights may also need to be considered'.*

265 The Grange was provided by and was in the ownership of the Council. All the staff, save for the Registered Manager, who attended the Grange for only up to two-and-a-half days each week, were either employed by the Council or were agency staff engaged by the Council. The Deputy Manager was a Council employee who had responsibility for the operational running

of the Grange and overall responsibility when the Registered Manager was not in attendance. The Council was responsible for the acts and omissions of its staff. I therefore find the failure to ensure that this important piece of safety equipment (the epilepsy mat) was in use was **maladministration** by the Council.

266 The failures by the Council relating to the provision of care to Mr Cannon and the failure by the Council to ensure that the epilepsy mat was in use also represent a failure by the Council to make reasonable adjustments to meet Mr Cannon's needs and resulted in him being treated less favourably for reasons related to his learning disability.

Action taken by the Council after Mr Cannon's injury

267 I have carefully considered the evidence submitted by the Council to demonstrate the actions it has taken following Mr Cannon's injury to improve the arrangements for respite care. I accept that some actions were taken immediately such as the termination of the contract with the Avenues Trust. I also note that the Grange has now closed and has been replaced by a modern facility which provides respite care for clients such as Mr Cannon. I have considered a recent Commision for Social Care Inspection report relating to this facility and note that within what is, in overall terms, a very positive report, concerns are still expressed about the quality of care plans and risk assessments for respite care clients. This was precisely the issue which was raised in earlier inspection reports regarding the Grange and which lies at the heart of the failure to provide Mr Cannon with adequate care. The Commision for Social Care Inspection report suggests that a lack of up-to-date care plans and risk assessments could potentially place clients at risk. In view of this evidence I believe that the Council has more to do in this vital area of care and I hope it will take the opportunity of this report to ensure that further improvements are put in place.

The Council's investigation of Mr Cannon's parents' complaints

268 I have considered the efforts made by the family to have the circumstances of their son's injury investigated by the Council. Both Mr Cannon's parents made formal written complaints to the Council within weeks of his injury and some time before his death. These complaints raised specific concerns about the care that he had received and asked for a full investigation to establish the facts. The Council's response to these formal complaints was extremely confused. The investigation report ordered by the Learning Disability Service Manager and produced by the First Independent Investigator was clearly produced for the purposes of an internal investigation within the Council. However, another part of the Council presented this investigation as being in direct response to the complaints made.

269 The initial complaints received no formal response and appear to have been discontinued with no more than a few acknowledgement letters. The report of the First Independent Investigator was not passed to Mr Cannon's father until the Second Independent Investigator suggested that this be done before any further investigation took place. He received the report in August 2004 and submitted detailed criticisms on behalf of the whole family which, once again, received no response. The Second Independent Investigator did not carry out an investigation nor did he produce a report and once the Coroner's inquest was announced the Council abandoned the complaints process. It was not unreasonable to suspend an investigation while the Coroner and police

were pursuing their enquiries, but these did not absolve the Council from its responsibility under the *National Health Service and Community Care Act 1990* to investigate properly made complaints, and there was no reason not to explain the reasons for the delay and to ensure that the complaints process was concluded promptly, without further intervention by Mr Cannon's family, as soon as this was possible.

270 In the event, Mr Cannon's parents were forced to restate their complaint time and time again and were given contradictory and unhelpful information about progress. Indeed, following the Coroner's inquest the Council declined to take the complaint forward and it did this in a manner which was bound to cause Mr Cannon's family deep distress. Mr Cannon's mother in particular was forced to seek my intervention before the Council initiated a Stage 2 investigation. The Council has accepted that errors were made at this time and that the way in which the decision to terminate the complaint was taken was insensitive and incorrect.

271 There was also a great deal of confusion about how the complaint progressed through the various stages of the complaints process. It was suggested that Mr Cannon's mother had found it difficult to know which stage the investigation had reached, the implication being that as she had resubmitted a fresh complaint the process had returned to Stage 1. This confusion was entirely the responsibility of the Council. Mr Cannon's mother thought she was at Stage 3 because this is what the Council had told her. This confusion added greatly to the distress the family were experiencing and raised fears that the Council was trying to obstruct the examination of the events at the Grange.

272 Having secured a Stage 2 investigation, Mr Cannon's family were entitled to expect that a full investigation would take place and that the Council would issue a formal response to them which addressed the failings identified. The report produced by the Third Independent Investigator supported the findings made by the First Independent Investigator and fully upheld the family's complaint that Mr Cannon had been provided with poor care by the Council. The subsequent letter to the family from the Head of Adult Social Services was the first time that the family had received a formal response to their complaint and this came nearly three years after Mr Cannon's injury. The response fell far short of an adequate consideration of the complaint made. The Head of Adult Social Services said he only partly upheld the complaint regarding the care that Mr Cannon had received but gave no explanation for this and did not acknowledge that this outcome differed significantly from the fully upheld verdict in the Third Independent Investigator's report. More importantly, the letter provided no apology for the shortcomings identified or the distress the family had suffered. The letter described the actions which had been taken to act on the findings of the investigation but these lacked substance and were so generalised that they did not provide evidence of specific action. In general, the response lacked sympathy and did not provide Mr Cannon's family with a satisfactory conclusion to their complaint.

273 The Review Panel hearing which constituted Stage 3 of the complaints process did no more than endorse and expand on the findings of the earlier investigations. Mr Cannon's mother received a very brief letter shortly after the hearing which told her that her complaint had been upheld and that the Review Panel expressed sympathy *'in respect of the whole issue'*. No apology was made and there was

no acknowledgement of the implications that the poor care, which was now accepted by the Council, had on Mr Cannon. His mother was told the Review Panel's only recommendation was that she should receive £250 for her trouble and the inconvenience of having to go through the complaints process. Once again, this letter lacked sympathy and was an inadequate outcome given the nature of the issues involved. The letter contained no details of the Review Panel's findings and Mr Cannon's mother had to wait another five months before the minutes of the meeting were made available to her. The failure to convey the outcome of the Review Panel hearing promptly to Mr Cannon's mother demonstrates a lack of sympathy or consideration for the ongoing distress that she and other members of the family continued to experience, several years after Mr Cannon's death.

274 I conclude that the manner in which the Council handled the complaints by Mr Cannon's parents fell far below an acceptable standard and was **maladministration** (as the Council now accepts).

Injustice

275 I have considered whether injustice was caused by the maladministration I have identified.

276 The Provider Care Plan and risk assessment were key documents to alert staff at the Grange to Mr Cannon's needs and to stipulate with precision how staff were to respond to them. Their preparation, on admission, would have ensured that care staff had drawn together the information available about Mr Cannon's care needs and made sure the requirements were fresh in people's minds. Their absence was not made good by the Care Assessment and Care Plan, previously produced by other professionals, or by an out-of-date risk assessment unlikely to have been drawn up by the staff who would actually care for him during the stay in question. There was, then, **some** relevant information on file but not the most relevant information: how the Grange and its current staff would meet Mr Cannon's needs and take all reasonable steps to keep him from harm. I have little doubt, had this documentation been in place, it would (among other things) have required the epilepsy alarm to have been in place and in working order on the night of Mr Cannon's accident; or, in the event that it could not for unforeseen reasons have been used that night, that alternative arrangements were made for his supervision.

277 The Coroner concluded that Mr Cannon's death derived directly from his accident at the Grange. Not all accidents can be avoided. But many can be foreseen and guarded against, and it was the purpose of the Provider Care Plan and risk assessment to do just that. In fact, the arrangements to define how staff would respond to Mr Cannon's needs, how they would keep him safe and seek to **prevent** accidents happening to him, and how they would be alerted to movements while he was in bed, were not in place. In all the circumstances the question arises whether Mr Cannon's accident and injury could have been avoided had proper arrangements been in place for his care (including an up-to-date Provider Care Plan and risk assessment properly communicated to staff, the epilepsy mat in place and working, and much closer supervision while he was in bed than actually occurred). It seems to me that had they been in place this accident and injury might well have been avoided, and probably should have been.

278 The failure to put in place all proper arrangements to guard against this accident, and as a consequence the beginning of the chain of circumstances that led to Mr Cannon's death, in my view represents a very substantial injustice to Mr Cannon's parents. No expressions of sorrow now, and no financial compensation, can ever assuage the hurt they feel. Even so, I believe that they are owed some significant recognition from the Council of its failures here and of their consequences.

279 The Council's complaint handling will have compounded the hurt of the main injustice. I accept that the circumstances here were very difficult for the Council. The police and Coroner's investigations will inevitably have complicated matters. It cannot have been an easy time for the Council or its staff. But the Council's failures of communication, and its lack of openness, can only have burdened and extended the grief felt by Mr Cannon's parents.

The actions of the Council: the Local Government Ombudsman's conclusion

280 In conclusion, I have considered all the available evidence and have found that the Council failed to provide and/or secure an acceptable standard of care for Mr Cannon and that, as a result, his safety was put at risk. That failure constitutes **maladministration** by the Council. I consider that the injury might well have been avoided and probably should have been if the failures I have identified had not occurred. I say this because the very procedures that should have been in place, and the availability of the epilepsy alarm, were explicitly designed to prevent such an accident happening to him. I also find that the Council did not respond to the complaint made by Mr Cannon's parents in an appropriate way and that this caused further distress to his family. That too was **maladministration**. The maladministration that I have found caused **injustice** to Mr Cannon's parents.

281 Therefore, I **uphold** Mr Cannon's parents' complaint against the Council.

Recommendations

282 I **recommend** that the Council formally apologise to Mr Cannon's parents for the failings I have identified, and make each of them an ex gratia payment of £10,000. I would also urge it to take all necessary steps to ensure that Provider Care Plans and risk assessments are properly in place for all persons in receipt of respite care commissioned by the Council.

The Health Service Ombudsman's investigation of the complaint against the Trust

Complaint (b): care and treatment at the Trust

283 Mr Cannon's parents complain that during each of his admissions the Trust failed to provide their son with adequate care and treatment or to properly plan his discharge and aftercare. They believe these failures led to the decline in his health and his death.

Key events

284 Mr Cannon was admitted to the Trust on three occasions. His first admission was on 27 June 2003 via A&E, following his injury at the Grange. His fractured leg was repaired and he was discharged to his mother's home on 4 July 2003.

285 Mr Cannon's second admission, on 8 July 2003, was also via A&E, following a visit by his GP earlier that day. The GP was concerned about Mr Cannon's ongoing pain and agitation. He was transferred to the Receiving Room and referred to a pain team who were unable to see him for several days. He was discharged into the care of his mother on 14 July 2003.

286 On 10 August 2003 Mr Cannon was admitted for a third time via A&E. He was found to be gravely ill, suffering from dehydration, malnutrition, renal failure and infection. He was treated initially in the Receiving Room but when his condition deteriorated he was moved to the ITU on 11 August 2003. His condition improved. He was transferred to the HDU on 13 August 2003 but his condition deteriorated once again and he suffered a cardiac arrest. After being resuscitated he was returned to the ITU on 14 August 2003 where he remained until 29 August 2003 when he died.

Mr Cannon's father's recollections and views

287 Mr Cannon's father told my investigator that his son's care during the first admission to the Trust had been generally very poor. He said his son was rarely attended and the family had to call nurses to help him. Mr Cannon's father said the family felt they were being ignored and that, instead of benefiting from the family's knowledge, staff were very defensive and regarded any communication from the family as criticism. He said nursing staff would not accept the family's attempts to inform them about Mr Cannon's disability, epilepsy, unusual distress and the pain he was suffering.

288 Mr Cannon's father said his son was clearly anxious and in pain following the operation and family members had to play an active part in his care at this time. He said nothing was done about the seizures his son was experiencing. The family recorded the seizures, but staff did nothing to control them. He said staff did not check the levels of epilepsy medication for over 80 hours after his operation. He also said no efforts were made to check blood loss until 60 hours after the operation, but when a doctor came he found that 40% of Mr Cannon's blood had been lost so an immediate blood transfusion was required.

289 Mr Cannon's father said appropriate observations were not carried out until he insisted they be done and other concerns expressed by the family were ignored. For example, Mr Cannon was not urinating normally and staff did not respond to the family's requests for a urinary catheter to be inserted.

290 Mr Cannon's father said that although the surgery to repair his son's broken bone had been successful, in all other respects he believed the hospital had failed to care for him. He said the only reason his son had survived his first admission was because of the family's efforts to convince staff to take notice of him.

291 Mr Cannon's father said his son's discharge on 4 July 2003 had been premature. He believes his son was not well enough to go home and no adequate arrangements had been made to care for him properly once he left the hospital. There was no care plan and no care package. Mr Cannon was in pain and extremely distressed but his father felt the hospital regarded him as a nuisance and could not cope with him. He said they wanted to get rid of him as quickly as possible.

292 Mr Cannon's father said he did not see his son following his discharge on 4 July 2003 as he went back to his mother's home. He said he did not visit his son during the second admission to hospital because he had no reason to think his condition was serious.

293 When Mr Cannon was admitted on the third occasion his father stayed at the Trust during the first night because of the seriousness of his son's condition. He said his son's bed was not visible from the nurses' station and he should not have been laid on his back, given the risk of vomiting and aspiration (inhaling stomach contents into the respiratory passages). Mr Cannon's father said nurses did little for his son during this time and most of the care was provided by his family. Mr Cannon's father said there was only one nurse on duty on the ward and conditions were extremely poor. He said another nurse was in the kitchen for two hours, asleep. He felt one nurse on duty for 12 or more patients was completely inadequate.

294 Mr Cannon's father said that while he was caring for his son, and out of sight of the nurse on duty, his son began coughing and a large amount of green bile flooded into the oxygen mask. He said he and his wife helped to clean up the vomit. Although the nurse did eventually attend to Mr Cannon she did not at any time attempt to summon her colleague who was sleeping in the kitchen. Mr Cannon's father also said that at the inquest the nurse reported she was present when Mr Cannon vomited into his mask. However, he was adamant that the nurse had not been present and his son had aspirated which he said led to the subsequent chest infection.

295 Mr Cannon's father said when his son was transferred from the ITU to the HDU on 13 August 2003 his condition was relatively stable, his renal function had recovered and he appeared to be on the mend. However, during his short stay in the HDU he went from being *'okay'* to being gravely ill. Mr Cannon's father described events during the morning of 14 August 2003. He said he was very concerned because his son was *'very pallid and his breathing very laboured'*, he was unresponsive and *'seemed unconscious'*. He described how Mr Cannon was seen by a doctor and a chest X-ray was taken. Around 1.30pm a consultant reviewed the X-ray and told Mr Cannon's family that his lung had collapsed; he was extremely ill and would be returned to the ITU. However, at around 3.00pm his son had a cardiac arrest. Mr Cannon's father believes his son was allowed to deteriorate unnoticed in the HDU and that staff ignored the concerns expressed by his family. However, he said following the cardiac arrest, Mr Cannon received good care in the ITU.

296 Mr Cannon's father explained his feelings about whether the care and treatment his son received was related to his learning disability. He said that in his view poor care and treatment were compounded by the failure of hospital staff to understand his son's individual needs and their refusal to involve family members. Overall, he said nurses failed to fulfil even the most basic duties such as monitoring his son's condition, administering medicines and alerting doctors to his son's changing condition. He felt that, whether hospital policy allowed it or not, it was completely inappropriate for nurses to be sleeping on the ward while patients needed attention. In his view, no nurse should ever be asleep while they are in charge of patients, especially critically ill patients. Mr Cannon's father said the failure of the nurses to provide

care led to catastrophic mistakes being made, such as the failure to maintain therapeutic levels of epilepsy medication and the failure to notice that Mr Cannon had lost a lot of blood. He said that if the hospital had provided Mr Cannon with the care and treatment he was entitled to he would still be alive.

Mr Cannon's mother's recollections and views

297 Mr Cannon's mother said that when she saw her son on 2 July 2003 in hospital he was extremely agitated and moaning a lot. She had initially assumed he was just unhappy about being in hospital. She said she had reassured him as much as she could and felt she should take him home as soon as possible as she knew he would settle down there. However, she was clear that when her son was discharged several days later, he was not well enough to go home. She felt more assessments and investigations should have been carried out. She asked for appropriate arrangements to be made for him to go home including inputs from the physiotherapy team. She said there were delays in obtaining medication from the hospital.
Mr Cannon's mother also said there were problems arranging visits from the district nurses after her son returned home and, despite assurances that the arrangements had been made, the district nurses were unaware they were expected to visit him. She said she had to make the arrangements for district nursing visits herself.

298 Regarding the general standards of care during Mr Cannon's admission to the Trust, his mother said she felt the hospital would not communicate with her and there was a general lack of care. She said she had to give her son his medication as nurses did not appear to want to do it. She also said staff did not know how to handle her son with regard to his learning disability and, consequently, left him unattended. Family members were left to care for him and to use their knowledge of what worked and what did not work with him to try and keep him comfortable.

299 Referring to Mr Cannon's admission to the Trust on 8 July 2003 his mother said there were numerous delays at the hospital. She said Mr Cannon was not seen by a doctor for some time in A&E and his wound dressing was not changed until family members asked for this. When he was eventually readmitted to a ward, there was a delay of several days before he was seen by a pain team and his medication modified. Mr Cannon's mother said that at the time of his admission her son was in *'hysterical pain'* and may have been in shock but no assessments were done to find out why he was in this state. Mr Cannon's mother said by the time her son was discharged on 14 July 2003 he had calmed down somewhat and was sleeping a little better.

300 Mr Cannon's mother said when her son was admitted for the third time she and her husband had stayed until midnight and were told by medical staff that Mr Cannon was very dehydrated, had kidney failure and was generally very poorly. They were told his condition was so serious that he *'might not make it'*. Mr Cannon regained consciousness and seemed to be improving but she said hospital staff asked whether he should be resuscitated should his condition worsen. She felt staff were trying to encourage her to *'let him go'* without making any effort to help him.

301 Mr Cannon's mother questioned why on his third admission her son was admitted to the Receiving Room and not the HDU or the ITU despite the seriousness of his condition. Before he moved to the ITU on 11 August 2003 his

condition had worsened. He was *'completely out of it'*, lethargic and hardly conscious. She said that in the ITU he received very good care and she was encouraged by the attitude of staff. She said she was told medical staff were *'looking through his disability'* and that they would *'try to save him'*. She said staff in the ITU were very caring and spoke to the family *'like human beings'*. However, she said she did not like the HDU which did not provide anything like the care he was receiving in the ITU. She said that the Sister was *'arrogant'* and unhelpful, the care was poor and her son's condition deteriorated. She said Mr Cannon developed a chest infection while he was in the HDU and his condition deteriorated seriously.

The Trust's position

302 The Trust's Director of Nursing and Clinical Governance produced a report, dated 18 May 2004, into the circumstances of Mr Cannon's care and treatment at the Trust. The report provided an overview of Mr Cannon's admissions and concluded there were no shortcomings in his care and treatment.

303 On 5 April 2007 the Trust's Chief Executive wrote a letter in response to recommendations from the Commission. He explained that the hospital in which Mr Cannon had been treated had now closed and services had been reprovided at another hospital. He acknowledged that the Trust had not responded fully to concerns raised by Mr Cannon's parents. He accepted that there had been some shortcomings in Mr Cannon's care and treatment, including lack of involvement of his family in some decisions, and offered some apologies. His focus was on improvements which had been made at the Trust since Mr Cannon's death, such as better record keeping, a review of discharge planning and changes to staffing.

The advice of the Health Service Ombudsman's Professional Advisers

304 My Professional Advisers have provided advice on key aspects of care and treatment during each of Mr Cannon's three admissions to hospital.

My A&E Medical Adviser

305 My A&E Medical Adviser studied the medical assessment carried out at around 6.00am on 27 June 2003 (the first admission) and noted that the medical team diagnosed a fracture of the shaft of femur. She said aspects of the medical assessment were *'very poor'* and pointed to lack of instructions on further management or observations. She also said:

> *'A drug chart shows that analgesia* [pain relieving drugs] *was not given until 10.15am, nearly five hours after triage. This is dreadful considering the history recounts that he was found screaming in pain and he is known to have a nasty fracture.'*

She also noted that Mr Cannon was not seen by orthopaedic doctors until 10.05am and said:

> *'I would expect a confirmed femur fracture to be seen and treated with far more urgency.'*

306 My A&E Medical Adviser went on to say an observation chart was not commenced until 10.00am and a fluid chart commenced at 4.00pm. She commented that these records:

'... appear to demonstrate no care at all between admission at 5.22am and 10.15am when [Mr Cannon was] *seen by the orthopaedic surgeons. There is no nursing note, no observation chart, no pain assessment and no analgesia. No one has made any investigation into this appalling omission.'*

307 With regard to Mr Cannon's second admission on 8 July 2003, my A&E Medical Adviser noted that he was triaged at 10.55am but it was not until shortly after 9.00pm that he was given a sedative and at 10.15pm he was given analgesia. She said a doctor recorded that Mr Cannon *'... seems in agony'* and an entry by the pain team on 11 July 2003 states that regular analgesic doses must not be missed and that Oramorph (an oral preparation of morphine) must be given when Mr Cannon was in pain. She said a pain monitoring chart was suggested, but notes of a return visit by the pain team later that afternoon indicate the suggested changes to analgesia had not been implemented.

308 My A&E Medical Adviser commented on the overall evidence of the hospital records for this period. She said:

'From these it does not look as if his pain was reliably controlled and he remained very agitated at times.'

She went on to make particular comment regarding Mr Cannon's second admission. She said:

'The delay and lack of care and pain relief on this occasion was totally unacceptable. Monitoring and assessment during this time was exceptionally poor and it seems that he was left in pain for unacceptable lengths of time. The other admissions show similar deficiencies. Mr Cannon was not, it seems, appropriately assessed for pain at any stage during the three admissions via A&E. Once the pain service became involved on 11 July [three days after admission] *there is evidence of improving monitoring but there is also evidence that pain control was not good and there continued to be difficulties.'*

309 My A&E Medical Adviser provided her opinion about the overall medical care Mr Cannon received during his three A&E admissions and his admissions to the Receiving Room. She said:

'I would say that the [lack of] *urgency with which his fracture was managed through A&E, the lack of attention to pain relief, and lack of monitoring whilst awaiting admission (apparently about eight hours) was not what I would expect as routine care in A&E.*

'...

'On his second admission, again there is a lack of documentation, unnecessary delay (11 hours) and lack of assessment of pain and analgesia. On the third admission when he was clearly very sick, although initial assessment was thorough and prompt, the delay (nearly eight hours) before transfer to a ward was worrying and I am not happy that we have sufficient evidence that he was transferred to an appropriate ward.'

310 She went on to compare the care Mr Cannon received to the care she would normally expect a patient in his condition to receive. She said:

'In short, I do not believe he received the standard of care that another patient should receive in similar circumstances.'

My A&E Nursing Adviser

311 My A&E Nursing Adviser said nursing staff in A&E often face situations where people cannot communicate and she would expect them to have the skills necessary to assess needs and make decisions about interventions based on clinical urgency in these circumstances. She said the information that carers can provide can be particularly important in such situations.

312 With regard to Mr Cannon's first admission to the Trust on 27 June 2003 my A&E Nursing Adviser is critical of both the nursing records and the nursing care provided in A&E. She said:

> *'The Triage priority status (the category allocated to each patient to denote the urgency of clinical treatment) appears to have been appropriate, however, there is little in the way of an objective assessment – the triage record consists mainly of Mr Cannon's presenting medical history. Although it is indicated that Mr Cannon had a "communication problem", there is no detail to inform colleagues how this affected him or how communication would be best achieved. No further detail was given in relation to his leg injury, nor any form of pain assessment carried out. This is poor practice.*
>
> *'Overall, the A&E nursing records for this first attendance were inadequate. Physiological observations were not repeated for five hours and the communication page included just one entry, indicating the baseline observations, and that a name-band had been placed on Mr Cannon. This represents an unacceptable level of nursing documentation in a seven-hour A&E episode and falls below the standards outlined by the* [Nursing and Midwifery Council].
>
> *'The level of nursing assessment, care planning and evaluation for this first A&E attendance fell below a reasonable standard of care. Little can be gleaned in terms of Mr Cannon's needs in relation to his communication difficulties and any strategies to address these through documentation of discussion with his carers. Formal pain assessment was absent, which is essential for any patient in distress, but even more so for someone like Mr Cannon, whose ability to articulate what he was feeling was compromised. The management and timeliness of his pain relief was also poor.'*

313 My A&E Nursing Adviser said that as Mr Cannon's second admission on 8 July 2003 was organised by his GP this should have meant further medical assessment on arrival at hospital was not needed, resulting in speedier progress through A&E. She said that on arrival at around 11.00am, Mr Cannon was appropriately triaged and the triage assessment form said he had been sent to A&E as a result of an increase in his epileptic seizures and agitation since his recent surgery. His severe learning disability was also noted. My A&E Nursing Adviser said:

> *'Aside from this and one recording of baseline physiological observations, there is no other informative or objective triage. Neither is there a secondary assessment, which one could expect …*
>
> *'No formal pain assessment is recorded and a single further set of observations exists on a chart at 5.00pm. Given that Mr Cannon's pulse rate was substantially raised on arrival, this is unacceptable practice.*
>
> *'…*

'It is clear that Mr Cannon's agitation continued throughout his stay in A&E and yet no one considered that this might have been in response to pain. There was no documented communication with Mark's family as to his normal behaviour at home or what strategies were routinely used for communication with him. Mr Cannon did not receive any pain relief until he had been in A&E for eleven hours, which is astonishing.'

314 My A&E Nursing Adviser considered the standard of care and treatment provided to Mr Cannon in the Receiving Room and found significant shortcomings in record keeping. She said:

'The formal Nursing Assessment document is blank except for the front page, which details the reasons for admission and demographic data. This is unacceptable in any situation and particularly for a patient with special needs. I was unable to locate any risk assessments, such as nutrition, falls, pressure ulcer prevention, or patient handling, which is also unacceptable.

'...

'Progress records are difficult to follow as they were ordered out of date sequence and one of the dates was entered incorrectly. In general they are detailed; however, they do not always reflect what I suspect to be Mr Cannon's true clinical status, for example, there are many occasions where the observation chart indicates a significant pulse increase, with no reference in the nursing records. One entry at 7.00pm on 9 July states "obs (observations) stable", yet his pulse rate at that time was 126, which is very high and by no means stable. On 10 July at 2.00pm, the record indicates that observations have been maintained – in fact, there was a gap in the recording of physiological observations of 11 hours between 7.00am and 6.00pm, at which time Mr Cannon's pulse rate was again 126 and his condition was described as "stable". The measurement was not repeated until 10.00pm that night. Mr Cannon was incontinent of urine at one stage and yet it is unclear whether this was a new event or whether he was prone to incontinence at home.'

315 My A&E Nursing Adviser noted that when he arrived in the Receiving Room, Mr Cannon was displaying signs of considerable pain. He was referred to a pain team on 9 July 2003. She noted that the Nurse Specialist from the pain team was unable to review him until 11 July 2003, apparently due to poor staffing resources. The Nurse Specialist from the pain team advised on alterations to Mr Cannon's analgesia and instructed that pain assessment charts be commenced. However, a numeric pain scale was used, implying that Mr Cannon was able to articulate how much pain he was experiencing on a scale of 1 to 10. My A&E Nursing Adviser is not convinced that this was the case and she considered an alternative tool, focusing on behaviour, would have been more appropriate. She considered the pain monitoring charts are not informative, as timings of pain assessments are unclear.

316 Regarding Mr Cannon's discharge home from the Receiving Room, my A&E Nursing Adviser said:

'The pre-discharge records in general are somewhat brief and do not reflect a considered and anticipatory discharge pathway. The nursing discharge record is completely blank.'

317 With regard to the whole of Mr Cannon's second admission to the Trust my A&E Nursing Adviser said:

'I was particularly concerned with the standard of the physiological observation records, such that action did not appear to have been taken at times when Mr Cannon's clinical status should have roused suspicion regardless of the cause and further the progress notes did not reflect what was written on the observations chart. Nursing records were incomplete – essential assessment documentation was blank and clearly-needed pain assessment tools were not instigated quickly enough and when they were, they were inappropriate. No risk assessments were carried out for Mr Cannon and discharge plans were blank. I am critical of the level of nursing care for this admission. Again, one could not get a sense of Mr Cannon's communication needs from any of the nursing records for this admission and that was very poor practice.'

318 My A&E Nursing Adviser said on Mr Cannon's third admission on 10 August 2003 record keeping was better. However, she was critical of the fact that there is no record of the insertion of a urinary catheter in the nursing notes and that *'a fluid balance record was not commenced until five hours after Mark's arrival ...'*.

319 She noted that Mr Cannon was transferred to the Receiving Room at around midnight on 10/11 August 2003 and that all clinical records from this point onwards refer to his previous surgery as THR (Total Hip Replacement), which was incorrect.

320 My A&E Nursing Adviser said that on admission to the Receiving Room, Mr Cannon's blood pressure was very low and his decreased conscious level placed him at serious risk of airway compromise (meaning that there was a risk that his windpipe could become blocked, for example, by vomit or his tongue, such that he would not be able to breath). Despite this, my A&E Nursing Adviser could not find any information from the records about the position in which Mr Cannon was nursed. She could not locate any nursing care plans, although she would have expected one to be drawn up as soon as possible after admission. She said she would have expected a patient with this level of deterioration to have been placed near to the nurses' station so his condition could be regularly and visually assessed. She also said the idea that:

'Mr Cannon could be observed by staff as they passed on their way to the sluice was astonishing. There could be no good rationale for locating him so far from the nurses' station. His learning disability was not the priority at that stage if this were to be used as a reason for more privacy – it was his physical state that was at great risk.'

321 Referring to the fact that nurses were sleeping in the kitchen during their breaks, my A&E Nursing Adviser said:

'The issue is not whether nursing staff contravened hospital policy in sleeping on their breaks, but whether the remaining staff on the ward were able to give safe care to their patients.'

322 With regard to record keeping she said:

> *'Staff chose to use a neurological observations chart to record Mr Cannon's vital signs. This was not appropriate in isolation, as patterns of fundamental observations, such as pulse rate, blood pressure and respiratory rates cannot be detected on this type of chart. Respiratory rates were not recorded at all, which is poor practice – the respiratory rate is recognised as one of the earliest and most sensitive signs of conditions such as sepsis (infection) and blood or fluid loss. I also note a significant drop in Mr Cannon's conscious level at 3.00am at a time when his blood pressure was not recorded at all. The readings were not repeated for another half an hour when they were the same, and then not for another hour. I would have expected a medical review when the Glasgow Coma Score (GCS – a mini neurological assessment which quantifies the level of consciousness) dropped by more than one point. The medical records show that the duty senior house officer was present at some time during the night but the entries are un-timed and I am not convinced that he was contacted at this time. There is a three-hour gap in recordings between 8.00am and 11.00am (at which time Mr Cannon's blood pressure was unrecordable). Mr Cannon was transferred to the ITU at 3.00pm.'*

323 In summary my A&E Nursing Adviser said:

> *'I have grave concerns about this admission. There is little information as to the cause of the extensive A&E delay, during which time the standard of patient monitoring was below an acceptable standard, as was the record keeping.*
>
> *'I have difficulty understanding why Mark Cannon was admitted onto a ward in an unconscious state with a low blood pressure and marked dehydration where there were only two nurses to provide care for 12 acute medical patients. The situation was not appropriate ...*
>
> *'...*
>
> *'The use of inappropriate observations charts for patients with deranged physiological readings worries me in an acute care environment, as does the apparent lack of action following a marked decrease in Mr Cannon's conscious level. A three-hour gap in recordings is not excusable.'*

My Orthopaedic Surgical Adviser

324 My Orthopaedic Surgical Adviser said when Mr Cannon was transferred from A&E to an orthopaedic ward he was rather agitated and it was decided that traction should not be applied. He considered this decision was appropriate. He noted that X-rays confirmed a spiral subtrochanteric fracture (fracture of neck of femur/hip) and that such fractures are invariably treated operatively. My Orthopaedic Surgical Adviser said:

> *'The fracture sustained by Mark Cannon is most commonly seen in younger patients in a high energy transfer situation such as a road accident or fall from a height. In patients with reduced mobility and relative osteoporosis such as the elderly or patients with low levels of activity, such fractures are more commonly seen after simple falls. It would be extremely unusual for such a fracture to occur spontaneously or in bed. It is possible therefore that Mr Cannon fell out of bed in his respite home, thus sustaining his injury.'*

325 Mr Cannon was scheduled for operative reduction and fixation of his fracture at the first available opportunity. Surgery was performed on 28 June 2003 and my Orthopaedic Surgical Adviser said the records indicate the operation was appropriate and performed satisfactorily.

326 My Orthopaedic Surgical Adviser commented on Mr Cannon's post-operative care. He said pain relief was given in the recovery room and:

> *'It was noted that there was no drainage from the peri-operative drain and his dressing remained dry indicating that bleeding had been controlled at the end of the operation and there was no continued bleeding in the post-operative period. I could find no clinical records made by the medical staff of the patient's post-operative state on 29 June 2003. I note that the operation was carried out on a Saturday and therefore the first post-operative day was a Sunday.'*

327 My Orthopaedic Surgical Adviser went on to explain that there should have been a formal handover at the weekend and it would have been appropriate for the operating surgeon to visit the patient on the first post-operative day. My Orthopaedic Surgical Adviser noted that on 30 June 2003 Mr Cannon started to have multiple seizures, his blood pressure was low, his urine output had decreased and he was in pain. He said a blood test taken at 10.15pm showed low haemoglobin which suggested bleeding had occurred. He noted that a blood transfusion was arranged and a urinary catheter was inserted.

328 My Orthopaedic Surgical Adviser said:

> *'Bleeding following the type of fracture sustained by Mr Cannon usually occurs in the immediate post injury period. The blood loss that generally occurs during the operative procedure is most often due to the evacuation of retained haematoma* [blood clot] *sustained after the injury. It is not uncommon for patients to lose up to three units of blood in the type of injury sustained by Mr Cannon.'*

329 My Orthopaedic Surgical Adviser considered that Mr Cannon should have been monitored more closely, particularly with regard to blood loss and urine output on the day after his operation. However, he also said:

> *'His remaining orthopaedic care during this admission seems to me to have been perfectly satisfactory.'*

330 My Orthopaedic Surgical Adviser concluded:

> *'I believe that Mr Mark Cannon's orthopaedic care was at a standard that would be accepted by most Orthopaedic Surgeons in the United Kingdom. The major deficiencies relate to delay in carrying out pain management, both on his initial and subsequent admission and delay in recognising the state of hypovalaemia* [decreased volume of fluid in the body] *and acute anaemia* [where the capacity of the blood to carry oxygen is low] *following his surgery. I believe this was largely due to unfamiliar staff being responsible for his care over the weekend of 29 to 30 June 2003. This matter should certainly be rectified by having formal handovers at weekends and by ensuring that a daily trauma ward round takes place seven days a week when all patients who have been operated on or admitted as emergencies are reviewed, preferably by Consultant staff.'*

My Orthopaedic Nursing Adviser

331 My Orthopaedic Nursing Adviser said he did not think *'the post-operative monitoring of Mr Cannon on the orthopaedic ward was of a satisfactory standard'*. He pointed to the fact that clinical observations were not carried out frequently enough during the first 24 hours and the fluid monitoring chart was incomplete for the day of the operation. He said:

> *'This falls below the standard of acceptable record keeping and means that staff could not estimate whether Mr Cannon's fluid input and output were balanced.'*

332 My Orthopaedic Nursing Adviser also noted that nursing records were incomplete on 30 June 2003. He said:

> *'Overall, I would say that the monitoring of Mr Cannon after his operation and the recording of that monitoring do not appear satisfactory. Clinical observations were sometimes not performed as frequently as good practice would dictate and monitoring of fluid balance was poor, with incomplete documentation.'*

333 With regard to Mr Cannon's epilepsy medication, my Orthopaedic Nursing Adviser said:

> *'... the medication chart indicates that 2 doses of carbamazepine* [epilepsy medication] *may not have been given before surgery – on the evening of 27 June and morning of 28 June – as the medicine was not available on the ward. However, the pharmacist has indicated on the chart that it was dispensed on 27 June, so I do not understand this. If it was available but not given then this would be a medication error and not good practice.*
>
> *'...*
>
> *'A formal seizure chart was only begun that evening* [30 June 2003]*, when it appears to have been completed by a relative of Mark Cannon and not the nursing staff. On 2 July the epilepsy nurse saw Mr Cannon at his mother's request. I am surprised that the nursing staff had not thought it appropriate to contact the nurse earlier as she may have provided valuable help and advice. The medical notes do not mention the need to check the levels of the epileptic medicine in Mr Cannon's blood until 1 July and the sample dated 2 July showed that he had a sodium valproate* [epilepsy medication] *level of 148 when the therapeutic range is 350-700 μmol/l.*
>
> *'From a nursing perspective it appears that the management of his epilepsy and epilepsy medication was not of a reasonable standard. Doses of epileptic medication may not have been given, the seizures were not recorded comprehensively and the nursing staff could have made better use of available information resources such as the epilepsy nurse.'*

My Anaesthetic Adviser

334 My Anaesthetic Adviser commented on Mr Cannon's third admission, specifically on care and treatment in the ITU and the HDU. He noted Mr Cannon was suffering convulsions, hypotension (low blood pressure), dehydration and agitation with a low consciousness level and said:

> *'The level of nursing supervision must be commented on – Mr Cannon had an impaired consciousness level. Maybe this was mistaken for his normal non-communicative self or possibly viewed*

as post-ictal [somnolence following a seizure]. *The nursing staff, if not sufficiently experienced to assess this, should certainly have been warned by the attending clinicians as to Mr Cannon's obtunded* [mentally dulled] *state. Aspiration of vomit was witnessed by members of his family and they have commented on the lack of immediate attention from the nursing staff. This is denied by the Trust particularly in the report by the Trust's Director of Nursing dated 18 May 2004. Whilst the nursing reports are confident that Mr Cannon was attended to and his airway was protected during the episodes of vomiting witnessed by the family, it is apparent from* [Mr Cannon's father's] *complaint letter that this was not a constant vigil. There is the possibility of a more insidious and silent aspiration in any patient with altered central protective reflexes and this risk would be increased if Mr Cannon was on his back. The picture gleaned from the respiratory findings that develop is of an "unprotected" airway admitting secretions and leading to the slow deterioration eventually necessitating ITU care.'*

335 My Anaesthetic Adviser also said:

'From the first notes in ITU, aspiration and its consequences are referred to as a working diagnosis complicating Mr Cannon's condition.'

However, he also commented that it is likely that had Mr Cannon aspirated he would have required an early diagnostic and therapeutic bronchoscopy and lavage (using a telescopic instrument to examine the respiratory passages and wash out any material which had been inhaled). He also noted that a test to analyse the levels of different chemicals in the blood did not suggest massive airway obstruction and this was in keeping with the Trust's position that Mr Cannon was nursed appropriately to prevent a significant aspiration.

336 My Anaesthetic Adviser commented on the decision not to resuscitate which was taken whilst Mr Cannon was in the Receiving Room. He said:

'There is one outstanding example where I feel the decisions made were radically different from someone of normal capacity. This is in the failure to aggressively consider treating Mr Cannon's acute renal failure with invasive monitoring and possible renal support (in the event dialysis was not actually required).

'...

'This attitude does suggest a value judgment by the medical team in a not very considered way.

'...

'It is inconceivable in my opinion that any 30 year old should ever fail to receive unquestioning, unqualified aggressive and immediate resuscitative care until it was apparent that all was hopeless. Fortunately, after pressure from Mr Cannon's father and discussion with [the Consultant Anaesthetist] *treatment was escalated with admission to ITU.'*

337 With regard to the care and treatment in the HDU on 13 and 14 August 2003, my Anaesthetic Adviser said the health records show that on the afternoon of 13 August 2003 Mr Cannon was breathing well without the support of a mechanical ventilator. He explained that

patients who do not need their breathing supported by a ventilator and do not need the full facilities of an ITU may be transferred to an HDU. In the circumstances, he thought it appropriate that Mr Cannon was moved to the HDU because, although he was very ill, his condition was stable.

338 My Anaesthetic Adviser said when Mr Cannon was transferred to the HDU he was a *'very sick young man'* who was receiving drugs to support his blood pressure. He said Mr Cannon needed close monitoring and there was evidence of regular review by clinical staff, including physiotherapists and doctors. My Anaesthetic Adviser said the records show staff were aware of the risk that Mr Cannon could deteriorate. They appropriately assessed and monitored his breathing during the morning and treated his chest infection with physiotherapy and antibiotics, and ordered blood tests and an X-ray to check whether his breathing was adequate. He said there is evidence that Mr Cannon's lungs were functioning adequately when the doctors saw him during the consultant ward round because the level of oxygen in his blood was adequate. He also said the doctors had hoped Mr Cannon's chest infection would resolve without further major intervention and there was no reason to intervene to support his breathing at this time.

339 My Anaesthetic Adviser said that at some point during the morning of 14 August 2003 a plug of sticky chest secretions blocked one of Mr Cannon's respiratory passages and this caused his lung to collapse. He said this *'could have occurred as a single acute event or as an undetectable gradual blockage during the preceding hours'* and that this development would not have been detectable. This blockage showed up on the chest X-ray and around 1.30pm doctors decided that Mr Cannon needed the support of a ventilator and should return to the ITU. However, around 3.00pm when Mr Cannon was having a tube passed into his windpipe to enable him to be connected to the ventilator, he suffered a cardiac arrest.

340 My Anaesthetic Adviser said although Mr Cannon's father felt staff on the HDU were not paying sufficient attention to his son there is evidence that they: were aware of the risk that he would deteriorate; did monitor his condition appropriately; and did take appropriate action when they detected the problem with his lung. He also said *'the events would have been exactly the same if Mr Cannon had remained on the ITU but the time intervals would have been shorter'*. He added that if Mr Cannon had been in the ITU:

> *'It is ... possible that the deterioration would not have been allowed to continue to the point where a cardiac arrest was a possibility.'*

341 My Anaesthetic Adviser was not critical of the actions taken by staff at the Acute Trust when Mr Cannon was in the HDU. However, he said that from Mr Cannon's father's account of events it appears staff had not communicated clearly with the family. He suggested that had they done so, the family would have realised that Mr Cannon was *'far from stable, that sputum retention and reintervention were a very real possibility but conservative measures were being tried first'*.

342 With regard to the care and treatment in the ITU my Anaesthetic Adviser said:

> *'I have reviewed the ITU entries up to 29 August. The picture is one of full and active treatment and the discussion of limiting treatment is only entered into when*

Mr Cannon has failed to respond to all treatment for multi organ failure. There is no suggestion in the notes that this ultimate end of life management was influenced by Mr Cannon's learning difficulty. It was certainly influenced by his "premorbid" [prior to death] *condition ...'*

My Community Nursing Adviser

343 My Community Nursing Adviser was asked to consider arrangements which were made for Mr Cannon's discharge.

344 My Community Nursing Adviser noted that properly recorded regular assessment of a patient's needs is essential to good care and to discharge planning. She said:

> *'Good discharge planning should, where possible, commence within 24 hours of admission and should include a full assessment of a patient's health and social care needs. I would expect to see evidence of discussion with the patient, relative, carer or friend as appropriate and evidence that this discussion included information regarding access and availability of community resources relevant to the individual's care needs. A named nurse and/or discharge facilitator/adviser should also be identified as a point of contact to provide support and advice to the patient/family as required.*
>
> *'For more complex discharges which, for example, require multiple agency involvement, large or complicated care packages or in circumstances where there are concerns regarding the "safety" of the discharge, I would expect at the very least evidence of multidisciplinary team collaboration and discharge planning. In some cases it may also be necessary to arrange a formal multidisciplinary meeting or case conference to plan for discharge. In any circumstance the involvement of the patient and/or their representative would be essential to the process.'*

345 With regard to Mr Cannon's first discharge my Community Nursing Adviser said:

> *'An initial nursing assessment was completed by* [a staff nurse] *on 27 June 2003 at 1.20pm. It is on a computer generated printed sheet and contains limited information regarding social situation and usual functional ability, Mark Cannon's height is recorded as 5 feet 6 inches and weight as 5 stone. There is no discussion regarding future rehabilitation or discharge planning needs at initial assessment or information regarding pre-admission levels of community support, for example, from the learning disabilities team, social services or district nurses or the frequency of respite care. This information, in my opinion, would have been essential in planning Mr Cannon's discharge.*
>
> *'There is evidence in the medical notes that occupational and physiotherapy staff were liaising with the family regarding safe transfers between bed and chair, the need for equipment and the necessity to bring Mr Cannon's bed downstairs. However, there is no evidence of a multidisciplinary and co-ordinated approach to his discharge or communication with Mr Cannon's family regarding discharge. I am surprised that there appears to have been no discussion with* [Mr Cannon's mother] *regarding the possibility of a care package and that a social services referral does not appear to have been made.*

'A district nurse referral was made requesting a visit for 7 June (three days after discharge) for wound care. There is limited information on the referral letter beyond this. There is no summary of the medical/nursing care Mr Cannon received during his period of in-patient care. His psychological state and understanding of condition/diagnosis are described as "not good" and in the communication section it is documented that Mr Cannon had learning difficulties. It would have been good practice and, I consider, a reasonable expectation for nursing staff to have contacted the district nursing service and discussed Mr Cannon's condition with a member of the district nursing team prior to his discharge in order to augment the information on the referral form particularly in light of the fact that a district nurse visit was not requested until three days post discharge. This would have given the district nursing sister the option of deciding if it would be more appropriate to organise an assessment visit prior to the date identified on the referral form. It would have also been reasonable to have contacted the community learning disabilities team to have informed them of Mr Cannon's discharge date.

'... it is quite clear to me that there were serious shortcomings in assessment and discharge planning (acute care) which led to serious gaps in communication and care necessitating readmission to hospital following a short and traumatic time at home for Mr Cannon and his family.'

346 With regard to the discharge arrangements following Mr Cannon's second discharge on 14 July 2003 my Community Nursing Adviser said:

'As with the previous admission, multidisciplinary and co-ordinated discharge planning is not apparent from Mr Cannon's clinical records. There is an entry in the nursing records indicating that Mr Cannon's mother would contact the district nursing team with regard to Mr Cannon's wound dressing. It would have been good practice for the ward nursing staff to have contacted the district nurses, particularly in view of the fact that he had been readmitted to hospital after only a few days following his previous discharge.'

347 My Community Nursing Adviser summarised her views on the arrangements made for discharging Mr Cannon from hospital on both occasions. She said:

'I have identified serious shortcomings in the assessment and discharge planning process in relation to the care of Mark Cannon. These were significant in both his first and second hospital admissions and it is my opinion that they had a considerable impact on the care delivery and level of support received by Mr Cannon and his family following discharge.

'The family and/or carers must at all times be central to all team and therapeutic activity if person-centred rehabilitation and discharge planning is to be achieved. It is apparent from the clinical records that there was a lack of engagement with the family or expert practitioners (e.g. learning disabilities team) which was clearly unacceptable and certainly contributed to a lack of understanding of Mr Cannon and the provision of person-centred care.'

My Learning Disability Nursing Adviser

348 I also sought advice from a specialist practitioner in learning disability nursing as to whether Mr Cannon's needs, as a patient with learning disabilities, were properly recognised and whether, all things considered, the care provided to him was adequate. She began by considering whether, during Mr Cannon's first admission to Oldchurch Hospital, the care pathways took reasonable account of his specific needs regarding his learning disabilities. She said:

> *'In my opinion the care pathways* [during Mr Cannon's first admission] *did not take reasonable account of Mr Cannon's specific needs resulting from his learning disability.*
>
> *'There was little evidence within the assessment undertaken by medical or nursing staff as to how Mr Cannon normally presents, his strengths and/or needs, his level of understanding or how he normally manages pain etc. This information would have helped the nursing and medical staff to gain an understanding of Mr Cannon as a person, understand when Mr Cannon was not himself and when help should be sought. Whilst I recognise that an admission of a person with a learning disability into the acute hospital setting can be difficult for all, this is exacerbated when medical and nursing staff fail to communicate effectively with the family, refer to others for specialist advice and/or refuse the help offered by family members. I would argue that this admission would have been made easier and certainly more comfortable for Mark if the hospital staff had listened and communicated more effectively with the family and had been accepting of the help offered by family members.*
>
> *'Management of analgesia has been identified as a key part of the care pathway for a fractured femur, but there is no evidence that this was a key part of the care pathway for Mr Cannon. This would have been better managed if there had been improved communication between Mr Cannon, the family and the hospital staff. His sister or any family member staying would have helped Mr Cannon and the hospital staff to understand his individual needs as a person with learning disability who had a fractured femur and how this affected the generic care pathway for a fractured femur.*
>
> *'Although learning difficulties was noted within Mr Cannon's pre-operative care plan, this information is not evidenced with the development of his 12 nursing care plans, other than he may have difficulty communicating due to "slurred speech and being epileptic". The care plans do not acknowledge or relate to Mr Cannon as a person with additional needs – i.e. eating and drinking, continence, bowel management, epilepsy, communication, understanding of Mr Cannon's pain etc.'*

349 My Learning Disability Nursing Adviser summarised her view of Mr Cannon's care during his first admission:

> *'In my opinion Mr Cannon was being nursed without an understanding and concern for his learning disability and how this may impact upon the care given. This understanding could have been achieved with improved communication between the hospital and the family carers who knew Mr Cannon really well.'*

350 Regarding Mr Cannon's second admission on 8 July 2003, my Learning Disability Nursing Adviser set out her view that his pain management may have been particularly poor because of the failure to take proper account of his needs. She said:

> *'I am concerned that Mr Cannon needed to become aggressive, make noises or hit himself before a stronger pain relief was administered. A person with a learning disability is not aggressive without a reason; it is often that people involved with their care do not understand the reason. There is no evidence within the record of any communication with the family of trying to understand Mr Cannon and his response to pain. The maximum dosage for the PRN* [as required] *medication was not administered with the staff waiting for Mr Cannon to voice his distress by making noises or via his behaviours. It is of concern that staff waited for this to occur and did not request further advice from the pain team to seek to effectively manage his pain.'*

351 My Learning Disability Nursing Adviser then commented briefly on Mr Cannon's third and final admission to the Trust. She said:

> *'There are numerous entries from the doctors with comprehensive assessments and requests for recordings and monitoring but there are once again no entries from the nursing staff; a concern when the doctors will be working with the observations and recordings from the nursing staff. There are other documents within the record i.e. the admission sheet from the HDU and the HDU daily record sheet, but not all are fully completed.'*

352 My Learning Disability Nursing Adviser also considered the extent to which hospital staff had sought the involvement of learning disability services or practitioners with learning disability experience during the planning and delivery of Mr Cannon's care. She said:

> *'There appears to be no evidence within the record of any involvement with specialist learning disability practitioners other than the Consultant in special needs with regard to his epilepsy after his second discharge from Oldchurch Hospital. In my opinion, involvement with learning disability services would have been both appropriate and of benefit to Mr Cannon and his family with regard to the understanding of Mr Cannon's individual needs; a person who was vulnerable within the acute hospital setting because of his learning disability.'*

Care and treatment at the Trust: the Health Service Ombudsman's findings

353 When Mr Cannon was well he had a lively sense of humour and enjoyed social events with his family and carers. Sometimes he just liked lazing around and sometimes he liked to join in activities and outings. However, after he broke his leg in the summer of 2003 his family encountered many difficulties in their attempts to meet his increasingly complex needs. His parents believe that staff at the Trust did not make enough effort to meet those needs.

354 Mr Cannon's parents believe that in respect of care and treatment, especially assessment, observation and monitoring, pain relief, management of epilepsy, decisions about resuscitation and discharge arrangements their son received less favourable treatment for reasons related to his learning disability.

Mr Cannon's parents believe that had different care and treatment been provided their son would not have died.

355 In Section 2 of this report I have set out the legislation and national and professional standards which should have guided Trust staff involved in Mr Cannon's care. Of particular relevance are the *Disability Discrimination Act 1995*, Good Medical Practice, the nurses' Code of Conduct, the Essence of Care benchmarks and Discharge from Hospital.

356 I have studied all the evidence available to me and carefully considered the advice of my Professional Advisers. I find that overall the care and treatment provided by the Trust for Mr Cannon fell below a reasonable standard. This was serious **service failure**.

357 I now consider the key areas where I have identified significant failings in Mr Cannon's care and treatment.

Pain management

358 I begin by considering the way in which Trust staff assessed and managed Mr Cannon's pain because, to my mind, this is the most striking and significant area of service failure.

359 As I have explained, Mr Cannon had only limited verbal communication, so he was not able to express his feelings of pain in a way which would have been familiar to staff. However, his family knew him well and were able to understand him and communicate with him. Certainly they knew when he was unhappy, uncomfortable or in pain. Trust staff should have carried out prompt and full assessments and used their own observations in combination with information and guidance from Mr Cannon's family to enable them to assess and manage his pain. There is clear evidence that they did not do this.

360 When Mr Cannon was first admitted to the Trust on 27 June 2003 he had a broken leg. I cannot begin to imagine the level of pain which he was experiencing, but it must surely have been severe. Therefore, I am seriously concerned about the lack of attention which staff in A&E gave to this aspect of his care. As my Professional Advisers have said, there is no evidence of any assessment of the level of Mr Cannon's pain and neither doctors nor nurses gave him any pain relief for over five hours. One of my Professional Advisers described this as a *'dreadful'* omission and another described it as an *'appalling omission'*. My Professional Advisers are usually measured in their assessment of clinical matters and do not often use such strong language to describe their findings. In this instance, I consider they are entirely justified in expressing themselves in this way.

361 Mr Cannon was admitted for a second time on 8 July 2003 and again there is disturbing evidence of the lack of immediate attention to controlling his pain. Mr Cannon's mother's description of events and the Trust records provide an upsetting picture of his condition. He was in severe uncontrollable pain, in distress, shouting, screaming, biting his hand, hitting his head against the wall and slapping his own face. His mother struggled to comfort him, but no one other than his family seems to have considered that Mr Cannon's behaviour might be the result of untreated pain.

362 My Professional Advisers were extremely concerned by this lack of attention to relieving Mr Cannon's pain on this day. Again they described their opinion about this in the strongest terms. My A&E Nursing Adviser said:

'Mr Cannon did not receive any pain relief until he had been in A&E for eleven hours, which is astonishing.'

My A&E Medical Adviser said:

'The delay and lack of care and pain relief on this occasion was totally unacceptable.'

363 My Professional Advisers have analysed Trust records for the remainder of Mr Cannon's second admission and they have advised me that the evidence shows pain management over the rest of this period was inadequate.

364 On 9 July 2003, the day after Mr Cannon was admitted for the second time, ward staff asked the pain team to visit as he remained in pain and was very agitated and distressed. His pulse rate was raised and he was biting his hands and banging his head. However, there is no evidence that ward staff, either doctors or nurses, made a considered plan for managing this pain. During this time records show pain relief was provided intermittently and at levels which would not have relieved Mr Cannon's pain.

365 When the Nurse Specialist from the pain team saw Mr Cannon, three days after his second admission, she produced a chart for recording pain assessment and immediately suggested a stronger analgesic should be given whenever he appeared to be in pain. However, ward staff did not obtain or administer this drug and records show it was not until the Nurse Specialist from the pain team returned later in the day that stronger pain relief was given.

366 Although better pain relief was given as a result of the actions of the pain team, I have concerns about their assessment of Mr Cannon's pain because records indicate numerical pain scoring documents were used which were based on verbal communication. Mr Cannon was not able to communicate in this way and, therefore, effective assessment could not have been carried out, even by the pain team because the scoring tool was inappropriate. My Professional Advisers have indicated that alternative methods of measuring pain using physical observations rather than verbal responses were available and should have been used to assess Mr Cannon's pain.

367 It is clear that in terms of urgent pain relief and assessment and planning for ongoing pain management, the standard of care and treatment Mr Cannon received from doctors, nurses and pain specialists at the Trust fell far below a reasonable standard. In this, the actions of neither doctors nor nurses met the requirements of their professional codes of practice and conduct. In addition, Mr Cannon had particular needs and because he could not communicate with staff in a way which was familiar to them it was all the more important that they should have sought the help of his family or carers who knew him well and were able to understand him. It appears that staff not only failed to proactively make use of such vital resources, but also ignored sustained efforts by the family to help and advise them. They should have adapted their usual practice to allow them to understand and meet his needs, but they did not do this. Consequently Mr Cannon was left in severe pain and great distress for prolonged periods of time. This was serious **service failure** which occurred for disability related reasons.

Assessment, observation, monitoring and record keeping

368 I have already described how doctors and nurses failed to assess and monitor Mr Cannon's pain. I now turn to assessment, observation, monitoring and record keeping as they relate to other aspects of his care and treatment.

369 My Professional Advisers have highlighted many instances when Mr Cannon was not properly assessed, observed or monitored by staff at the Trust.

370 During the first admission to A&E Mr Cannon's fractured leg was quickly diagnosed and baseline observations were made. However, after this, little more was recorded by nurses or doctors. In A&E there was no nursing assessment, care plan or adequate monitoring of his basic condition. There was no attempt to assess his communication needs or develop plans to meet those needs. After initial review, it seems Mr Cannon received no medical attention until he was seen by a trauma team around five hours later. My A&E Medical Adviser confirmed that Mr Cannon was left too long without medical attention.

371 My Orthopaedic Surgical Adviser confirmed that Mr Cannon's operation was performed without significant delay and that there were no problems with the surgical procedure. However, his post-operative care on the ward appears far from satisfactory.

372 Mr Cannon's surgery was performed on a Saturday and it appears that staffing arrangements over the weekend were such that he received minimal medical supervision until Monday, when the usual orthopaedic team returned. There are no medical records at all for 29 June 2003 and it appears Mr Cannon's medical care was left in the hands of the duty team who would also have been covering A&E. My Orthopaedic Surgical Adviser said a trauma team should have been available seven days a week, the consultant should have visited on the day after the operation and a more formal handover should have been organised. Good Medical Practice requires that care is properly co-ordinated and communicated to the staff to whom care is delegated. This did not happen.

373 My Professional Advisers agree that, following his surgery, Mr Cannon's fluid levels, blood pressure and other observations needed to be monitored regularly to pick up signs of blood or fluid loss after the operation. On the second day after his surgery, Mr Cannon was having multiple seizures and his condition deteriorated such that he needed an urgent blood transfusion. However, observations remained intermittent throughout the post-operative period. The failure to assess, observe and monitor Mr Cannon during this critical period and the failure to keep adequate records falls short of what is required in Good Medical Practice and the nurses' Code of Conduct.

374 When Mr Cannon was admitted for a second time he was seen in A&E but then had to wait five hours before he was seen by the duty medical team and shortly afterwards by the orthopaedic team. There was then another wait of around five hours before he was admitted to the Receiving Room. My Professional Advisers have confirmed that the process of assessment and observation in A&E at this time was poor and few records were made about Mr Cannon's condition.

375 On his third admission Mr Cannon was taken directly to the resuscitation room which was appropriate given his very serious condition. My Professional Advisers confirmed that at this time staff made a reasonable assessment and diagnosis of his condition. However, after that assessment record keeping was poor, for example, no fluid balance chart was started despite the probable diagnosis of dehydration and renal failure. My Professional Advisers said assessment, monitoring and record keeping remained poor after Mr Cannon was transferred to the Receiving Room, for example, neurological charts were used and these did not allow adequate monitoring of Mr Cannon's condition.

376 Furthermore, it is clear that observation and monitoring of Mr Cannon in the Receiving Room was not adequate. Mr Cannon's father described how he and his wife were left alone to manage Mr Cannon's care, even though he was very ill and not fully conscious. Mr Cannon's father believes this lack of professional supervision and attention to his son's needs meant that when Mr Cannon vomited during the night of 10/11 August 2003 he inhaled vomit and this led to his subsequent chest infection. I do not doubt Mr Cannon's father's version of events; however, my Anaesthetic Adviser has said it is not possible to say for certain whether or not Mr Cannon inhaled vomit that night, although he did think it likely that someone in Mr Cannon's condition would be at risk of aspiration in this way. Whatever actually happened regarding this episode may be disputed, but what cannot be disputed is the fact that Mr Cannon, a very ill, partly conscious patient with particular needs related to his learning disability, was left for too long without adequate professional attention.

377 Having studied available evidence and taken account of the advice of my Professional Advisers, I find that during all three admissions to the Trust there were shortcomings in assessment, observation, monitoring and record keeping. There is evidence that these shortcomings occurred in A&E, the orthopaedic ward and the Receiving Room. Professional staff did not act in line with their professional codes of conduct and the care Mr Cannon received fell below a reasonable standard. There is no evidence that staff adjusted their practice to meet Mr Cannon's particular needs. This was **service failure** which occurred at least in part for disability related reasons.

Management of Mr Cannon's epilepsy

378 Mr Cannon's family have concerns about the way in which Mr Cannon's epilepsy was managed. Mr Cannon's father believes the failures to monitor his son post-operatively left him with insufficient levels of anti-epilepsy medication in his blood. My Professional Advisers agreed and have also drawn attention to other episodes when clinical staff at the Trust paid insufficient attention to managing Mr Cannon's epilepsy. They said the failure to manage Mr Cannon's epilepsy may have begun in the period before he had his operation. They noted two doses of his epilepsy medication were prescribed for Mr Cannon in the period before his operation. Pharmacy records indicate that medication was dispensed. There is no record that Mr Cannon received it.

379 Mr Cannon suffered many seizures post-operatively, but he was not seen by an epilepsy nurse until his mother intervened. On 2 July 2003 a seizure chart and alterations to his medication were instituted. In fact, the seizure chart was completed by his family, not by nurses. My Professional Advisers said these were significant failures and may have increased the frequency of Mr Cannon's seizures and increased his agitation. I have seen no evidence that staff made adjustments to their actions to ensure they met Mr Cannon's particular needs.

380 I have considered the advice of my Professional Advisers and I find the failures to properly monitor Mr Cannon's seizures, to provide him with his medication as prescribed, and the failure to seek input from a specialist nurse without prompting are not in line with the standards set out in Good Medical Practice and the nurses' Code of Conduct and I consider the care afforded to Mr Cannon fell well below a reasonable standard. I regard this as **service failure** which to some extent was for disability related reasons.

Discharge arrangements

381 Twice during July 2003 (4 and 14 July) Mr Cannon was discharged to his mother's home following admission to the Trust. On each occasion he had been in hospital for just over a week following emergency admission, related initially to a fractured leg and subsequently to problems including infection and dehydration.

382 It is understandable that Mr Cannon's mother was keen to have her son home. She naturally felt it would be best to get him home as soon as possible because she hoped he would settle down in familiar surroundings where his family, who understood his needs and responses, could care for him appropriately. What I cannot understand is how a range of healthcare professionals at the Trust did not properly assess the risk of discharging Mr Cannon to his mother's care without arranging proper community support. In these circumstances, it is not at all surprising that Mr Cannon's mother struggled to manage her son at home.

383 After the first admission the evidence shows that Mr Cannon was discharged without even the most basic post-discharge arrangements. The ward staff failed even to arrange for community nurses to visit to change Mr Cannon's dressings. His mother had to make a telephone call to request a visit. The letter from ward staff to the community nurses was sent after Mr Cannon was discharged and lacks any detail which would allow proper planning for his care at home. His mother was expected to take responsibility for managing her son's care and to call on health and social services herself. She already had enough to do and worry about. It was not acceptable to place her in this position – without proper professional help and unsupported by services which should have been arranged to help her care for her son.

384 Mr Cannon's discharge after his second admission again appears to have been completely unplanned. My Professional Advisers found little evidence that appropriate thought had been given to his readiness to return home and that no appropriate plans had been prepared to support his mother. My Professional Advisers have told me that comprehensive plans should have been put in place on the basis of multidisciplinary liaison. In fact, the discharge documents were left blank. There was no preparation and no plan. Mr Cannon was simply returned home without additional support of any kind for his mother.

385 In Section 2 of this report I have set out key aspects of the Department of Health document Discharge from Hospital, which clearly sets out the way in which discharge from hospital can be arranged in a safe and effective way. The guidance emphasises the importance of discussions with relatives and carers, identification of community resources (such as learning disability teams, social services and community nurses) relevant to the patient's needs and, in complex cases such as Mr Cannon's, more intensive multidisciplinary input into the discharge process. My Community Nursing Adviser has told me what should have happened when Mr Cannon was discharged and has confirmed that what should have happened did not happen. There was no multidisciplinary liaison, no discharge plan and no arrangement for home support.

386 On two occasions in July 2003 the Trust failed to ensure that Mr Cannon was discharged safely. Staff did not act in accordance with relevant government guidance or their codes of professional conduct. This meant Mr Cannon was discharged without due concern for his safety and community healthcare resources

were not fully aware of his condition or the level of support he would need. Staff at the Trust did not properly consider his particular needs and his mother was left to care for him and to arrange help as best she could. This was serious **service failure** which occurred at least in part for disability related reasons.

The decision in the Receiving Room not to resuscitate Mr Cannon

387 On 11 August 2003 Mr Cannon's condition deteriorated, and my Anaesthetic Adviser said it appears a decision was made *'not to treat'* by relatively junior medical staff on the basis of Mr Cannon's persistently impaired consciousness and blood pressure which was not responding to simple treatment. My Anaesthetic Adviser suggested that at this time Mr Cannon was not treated in the way someone of *'normal capacity'* would have been treated. He suggested a value judgment had been made by the medical team who came to a premature decision not to resuscitate Mr Cannon when, it was possible that his condition could be reversed.

388 The General Medical Council provides guidance about doctors' duties when treating people who lack capacity. *Seeking Patients' consent, the ethical considerations*, makes it clear that wherever possible treatment options must be kept open and decisions about care and treatment should be explained to family and carers. The guidance says the reasons not to resuscitate should be clearly documented and should take account of the views of family and carers. In Good Medical Practice, the General Medical Council says those with responsibility for junior medical staff should ensure that they understand their roles and that they are properly supervised.

389 It is clear that in this instance junior doctors should not have been left in a situation where they could make a decision about whether or not to resuscitate Mr Cannon. There is no evidence that they knew how to make a decision of this nature according to the law and professional guidance taking into account Mr Cannon's best interests. They should have been supervised by a consultant. In the event it is clear that they made an inappropriate, value-based judgment. This was serious **service failure** which occurred for disability related reasons.

Care in the ITU and the HDU

390 Once Mr Cannon arrived in the ITU on 11 August 2003 his condition stabilised and he received appropriate supervision and active treatment which reflected the seriousness of his condition. For the first time, his family were satisfied that their son was in good hands. However, Mr Cannon was transferred from the ITU to the HDU on 13 August 2003 and he was there for only a short time before his condition deteriorated, he suffered a cardiac arrest and was transferred back to the ITU.

391 It is clear from the account provided by Mr Cannon's father that family members were greatly concerned about Mr Cannon's condition when they saw him in the HDU on the morning of 14 August 2003. They thought staff were not paying adequate attention to Mr Cannon and had not recognised how ill he was. When his lung collapsed and he subsequently suffered a cardiac arrest they understandably took this as evidence that he had not received appropriate care and treatment. However, my Anaesthetic Adviser told me that although Mr Cannon was very ill his condition was stable and, therefore, the 'wait and see' plan of care and the care and treatment provided in the

HDU were appropriate. He also told me staff acted reasonably in the way they observed, assessed and treated Mr Cannon's condition. In particular, I note my Anaesthetic Adviser's advice that Mr Cannon was very ill and at risk of developing a collapsed lung caused by a plug of secretions and that he would have suffered this complication even if he had stayed in the ITU.

392 That said, it is clear to me that staff did not communicate effectively with Mr Cannon's family who, consequently, did not fully appreciate how his care and treatment were being managed. Specifically, they did not know staff were aware of the risk of sudden decline and were monitoring Mr Cannon appropriately for just such an event.

393 I have identified a shortcoming in the service provided for Mr Cannon while he was in the HDU, namely ineffective communication with his family. However, I find that other key aspects of his care and treatment were of a reasonable standard in the circumstances. Therefore, on balance, I find that any shortcomings in the care and treatment provided at this time **do not amount to service failure**.

394 My Professional Advisers have said that the care Mr Cannon received on his return to the ITU was of a very high standard.

Care and treatment at the Trust: the Health Service Ombudsman's conclusions

395 In relation to Mr Cannon's parents' complaints about their son's care and treatment at the Trust I conclude that there was significant **service failure**, at least some of which was for disability related reasons. The key service failings were:

i. management of Mr Cannon's pain was inadequate because his urgent need for pain relief was not met and assessment and planning for ongoing pain management was not of a reasonable standard;

ii. assessment, observation, monitoring and recording of Mr Cannon's condition was inadequate, particularly during his three admissions to A&E, during the first days following his operation and when he was in the Receiving Room on his third admission;

iii. management of Mr Cannon's epilepsy was inadequate because his seizures and medication levels were not properly monitored and his medication was not always given as prescribed;

iv. on two occasions discharge arrangements did not meet the standard set out in government guidelines; and

v. the first decision not to resuscitate Mr Cannon was not appropriate and did not conform with legal and professional guidance.

Complaint (c): complaint handling by the Trust

396 Mr Cannon's parents believe the Trust has failed to investigate the family's complaint about their son's care properly or to apologise for the many shortcomings which they believe occurred. Mr Cannon's father told my investigator he was completely dissatisfied with the Trust's response to his complaint.

The complaint to the Trust

397 In his complaint letter to the Trust dated 9 September 2003 Mr Cannon's father provided a detailed account of the care and treatment his son had received. This included a day-by-day narrative account of his son's care, clearly identifying what he believed were the major shortcomings. In his letter, Mr Cannon's father said that his son had:

> *'become the victim of an astonishing lack of care and blunders of the most extraordinary kind by people who neither paid heed to, listened to, understood or noticed symptoms and indications of how critically ill Mark was becoming. It was this disregard, omissions, errors of judgment, blunders that ... were to progressively be the cause of our beloved son Mark's demise.'*

398 He said that each day in the Trust's care had lessened his son's chances of survival. He set out his concerns about a general lack of care which he attributed to his son's learning disability which made it necessary for his family to try to communicate on his son's behalf to hospital staff.

399 Mr Cannon's father said his family's attempts to communicate his son's needs were ignored. He also attributed his son's decline, which he said went unnoticed, to the inability of hospital staff, both nurses and doctors, to see beyond his learning disabilities. He also raised a number of specific issues which he said had been instrumental in his son's decline and subsequent death. These included his recollection that nurses were sleeping regularly on duty which led to a lack of supervision which in turn led to his son vomiting and aspirating bile which caused his pneumonia. Mr Cannon's father said this was *'the prime cause of Mark's chest infection leading to a profound overnight deterioration, cardiac arrest and the fatal infection that finally overwhelmed Mark'*. Mr Cannon's father said inattention by Trust staff, related to his son's learning disability, resulted in medical and nursing care not being given and his declining health not being noticed. He also asked for answers to a number of questions relating to issues such as blood loss, the efficacy of epilepsy medication, discharge arrangements and general nursing and medical care.

The Trust's response to the complaint

400 The Trust began internal enquiries into the complaint but did not proceed because of the police investigation and Coroner's enquiries. On 29 September 2003 the Trust's Chief Executive wrote to Mr Cannon's father explaining the situation and indicating that there might be a considerable delay before he received a response.

401 On 24 August 2004 the Trust sent Mr Cannon's father a copy of a report, dated 18 May 2004, about the care of his son. Extracts from the report, including the detail of the conclusion, are set out at Annex C. In the report, the Trust's Director of Nursing and Clinical Governance provided an overview of Mr Cannon's care and concluded that his care had been reasonable and that he was actively managed during the time he was in the hospital's care. She did not identify any significant shortcomings in his care.

402 Some time in March or April 2005 the Trust sent an undated letter to Mr Cannon's father's MP indicating that the Trust's report represented the formal outcome of its consideration of his complaint. The Trust also pointed out that the inquest had not attributed Mr Cannon's death to a lack of care in hospital.

403 Mr Cannon's father wrote to the Trust's Chief Executive asking for further information. The

Chief Executive replied on 29 June 2005, saying he regarded the report of 18 May 2004 as the Trust's full response to the complaint.

The Trust's response to the outcome of the Healthcare Commission's review

404 Mr Cannon's father was dissatisfied with the Trust's response and complained to the Healthcare Commission. The Healthcare Commission's decision letter was issued on 20 December 2006 and contained a number of specific recommendations.

405 On 5 April 2007 the Trust's Chief Executive responded to the Healthcare Commission's recommendations. He explained that the hospital where Mr Cannon had been treated had closed and services had been reprovided at another hospital with better ward facilities. His response focused on improvements at the Trust since Mr Cannon's death and included information about changes in arrangements in areas which were the focus of the complaint, for example, record keeping, discharge planning and pain assessment documentation.

406 The Trust's Chief Executive accepted that there had been some shortcomings in Mr Cannon's care and treatment, such as liaison with the family, administration of medicines and the time Mr Cannon waited in A&E before being admitted to a ward. However, there was no overt acceptance that in other key areas, such as pain relief, the Trust had failed to provide a reasonable standard of care and treatment, and there were no clear apologies for those failings. The Trust's Chief Executive acknowledged that the Trust's response to the complaint *'did not address* [the family's concerns] *in a satisfactory and comprehensive way'* and for this failing he offered his *'sincere apologies'*. He also said:

> *'I would wish to extend my sincere apologies to* [Mr Cannon's family] *for the length of time it has taken to resolve* [their] *concerns regarding Mark's care and treatment.'*

Complaint handling by the Trust: the Health Service Ombudsman's findings

407 Mr Cannon's father complained to the Trust in September 2003 when, as I have described in Section 2 of this report, the procedures for handling complaints against the NHS were set out in various Directions produced by the Secretary of State. Therefore, I have compared the Trust's actions at the local resolution stage with the requirements of these Directions. However, the complaint was reviewed by the Healthcare Commission under the *NHS (Complaints) Regulations 2004*, which I have summarised in Section 2, and these Regulations apply to the Trust's response to the Healthcare Commission's review.

408 Mr Cannon's father complained on 9 September 2003, expressing detailed criticisms and concerns about his son's care and treatment. The Trust should have investigated his complaint in accordance with policy and provided him with explanations about Mr Cannon's care and treatment. This did not happen. Instead, the Trust told Mr Cannon's father that it could not respond to his complaint because the police and the Coroner were investigating his son's death. On 29 September 2003 the Trust's Chief Executive informed Mr Cannon's father that there might be a considerable delay before he received a response. There was no reason for this unacceptable delay because there was no reason why action by the police or the Coroner should have delayed the Trust's investigation or response. This was **maladministration**.

409 In fact, at some point the Trust did conduct an investigation and a report was produced by the Director of Nursing and Clinical Governance. As I have said, this report was produced in May 2004, but it was not shared with Mr Cannon's family until August 2004. The Trust told Mr Cannon's father, and subsequently his MP, that this report represented the Trust's final response to the complaint. However, the report was limited in scope as it focused mainly on the nursing care which Mr Cannon received and it did not address many of Mr Cannon's family's concerns. Moreover, given the significant service failings which my investigation has revealed, it is clear that the Trust's investigation, which identified no shortcomings whatsoever in Mr Cannon's care and treatment, was inadequate. This was **maladministration**.

410 The report was sent to Mr Cannon's father on 24 August 2004 and, therefore, it would have arrived around the first anniversary of his son's death. In addition, in one instance, the report incorrectly records Mr Cannon's date of death as 1 September 2003. The impact of this significant error of fact is compounded by other insensitivities in the report. For example, the report refers to a *'difference of opinion'* between Mr Cannon's parents and makes reference to Mr Cannon's *'inability to understand the care process'* as a reason for his distress. The Trust should have demonstrated a caring and conciliatory approach. Instead its response was defensive and insensitive. This was **maladministration**.

411 It was not until the Trust was asked to respond to the shortcomings in care and treatment identified in the Healthcare Commission's review that Mr Cannon's family received any acknowledgement of failings or apologies from the Trust. I recognise that the Healthcare Commission's recommendations focused on asking the Trust to inform Mr Cannon's family about progress which had been made since Mr Cannon's death and that the Trust's Chief Executive framed his response in this way. That said, this would have been an opportunity for the Trust to offer further explanations as well as acknowledge and apologise for the failings in Mr Cannon's care and treatment. Although the Trust's Chief Executive acknowledged some failings and offered some apologies these did not by any means cover all the shortcomings in Mr Cannon's care and treatment. The Trust's Chief Executive apologised that it had taken so long to resolve the family's concerns when the family were, rightly, far from satisfied with the Trust's response. This was **maladministration**.

Complaint handling by the Trust: the Health Service Ombudsman's conclusions

412 I conclude that there were major failings in the way in which the Trust handled Mr Cannon's father's complaint. Specifically the Trust failed:

i. to properly investigate the complaint;

ii. to provide an appropriate response which covered all the issues complained about;

iii. to handle the complaint with appropriate sensitivity; and

iv. to take opportunities to offer full explanations and appropriate apologies.

413 In these respects the Trust failed to comply fully with the applicable standards for complaint handling. Its actions did not accord with principles of good administration and it did not provide an appropriate or adequate remedy. These failings amount to **maladministration**.

414 However, I have found no evidence which indicates that these failings in complaint handling were for disability related reasons.

The complaint against the Trust: the Health Service Ombudsman's conclusions

415 I am in no doubt that the Trust failed to provide a reasonable standard of care and treatment for Mr Cannon. In particular, Trust staff did not meet his needs in terms of pain relief, management of his epilepsy, or assessment, observation and monitoring of his condition. In addition the Trust failed to maintain proper records, a decision about resuscitation status was not in line with legal and professional guidelines and on two occasions staff made inadequate plans to ensure Mr Cannon's safe discharge. I consider this **service failure** was at least in part for disability related reasons.

416 **Maladministration** in the Trust's complaints process meant Mr Cannon's family's questions about the care and treatment he received were not properly addressed by the Trust in an appropriate, efficient and timely way.

Injustice

417 The Trust has informed me of actions it has taken to address the failures in the service it provided for Mr Cannon. These actions include:

- introducing a Safeguarding Adults Policy and setting up a Safeguarding Adults Board;
- developing guidance for enabling patients with learning disabilities to access the Trust's services;
- introducing communication tools to aid communication with people with learning disabilities;
- providing training for professional staff on the implications of the *Mental Capacity Act*; and
- introducing specific advocacy services for people with learning disabilities.

418 I recognise that these measures represent improvements at the Trust based on learning from failings in Mr Cannon's care and treatment. Nonetheless, I conclude that had the Trust provided appropriate and reasonable care and treatment according to existing standards and guidance, it is likely Mr Cannon's suffering would have been less and it is possible that he would have survived. Furthermore, his family would have suffered less anxiety and distress. These findings represent **unremedied injustice**.

419 I conclude that service failure and maladministration at the Trust have led to unremedied injustice to Mr Cannon's parents.

420 Therefore, I **uphold** Mr Cannon's parents' complaint against the Trust.

421 We say more about injustice in Section 4 of this report.

The Health Service Ombudsman's recommendations

422 I **recommend** that the Chief Executive of the Trust apologise to Mr Cannon's parents for the failings I have set out in this report.

423 I also **recommend** that the Trust offer compensation of £10,000 to each of Mr Cannon's parents in recognition of the injustice they have suffered in consequence of the service failure and maladministration I have identified.

The Trust's response

424 The Chief Executive of the Trust wholly accepted my recommendations. He assured me he will send a full apology to Mr Cannon's parents. He also assured me that changes had been made and lessons learnt as a result of this case. The Chief Executive accepted my recommendation regarding a compensation payment.

The Health Service Ombudsman's investigation of the complaint against the Practice

Complaint (d): care and treatment by the Practice

425 Mr Cannon's parents complain that the Practice failed to provide their son with adequate care and that more could have been done to diagnose the factors underlying the deterioration in his condition following his discharge from the Trust in July 2003.

Key events

426 At Annex D I have summarised key events relating to Mr Cannon's care and treatment by the Practice from 4 July to 10 August 2003. This summary is based on my GP Adviser's review of Mr Cannon's health records.

Mr Cannon's mother's recollections and views

427 Mr Cannon's mother said that after he was discharged on 4 July 2003 her son's condition was *'terrible'*. He was not sleeping and was in constant pain. He repeatedly slapped his own face and would not use his commode. She said she called the GP who came to see Mr Cannon and said he was not sure what was wrong but he thought there may be some underlying problem causing her son to be agitated. She said the GP recommended that Mr Cannon returned to hospital so that his condition could be further investigated and he arranged his readmission later that day.

428 Mr Cannon's mother said that by the time her son was discharged on 14 July 2003 his family had managed to calm him down a little and he was sleeping a little better. However, she said her son remained very agitated and was obviously in pain. She said she and her husband were finding it quite hard to cope with Mr Cannon at home. They were up all night and found it exhausting to care for him in his agitated state. They felt they were at the end of their tether and, via the Day Care Centre, they asked for further respite care at a home other than the Grange. This was arranged for four or five days at the end of July 2003.

429 Mr Cannon's mother said that on his return from respite care her son appeared to be sleeping a bit better but his condition started to deteriorate quickly. He was not eating and had a high temperature. He was also having frequent seizures and was dehydrated. She said Mr Cannon did not seem to be *'right'* at this time and she was very concerned about his condition. On 6 August 2003 she contacted the GP following a home visit from the Learning Disability Consultant. She said the GP came,

examined Mr Cannon and prescribed antibiotics. At this time she said her son was dehydrated, had a high temperature, was having seizures and losing weight. Mr Cannon's mother said she could see he was deteriorating rapidly and was surprised the GP had not noticed the seriousness of his condition and immediately readmitted him to hospital. She said the district nursing staff had only seen her son once during all the time he was home from hospital.

The GP's response to my enquiries

430 In response to my enquiries, the GP who had visited Mr Cannon at home during the events complained about provided a statement in which he said he had very little contact with the patient and could not recall the details of the visits he made. However, he provided the following summary based on Mr Cannon's health records:

> *'On the 8th July 2003, a home visit was requested and I saw him at home with a history of increased agitation and difficulty sleeping at night despite diazepam. The patient indicated that he had discomfort with his bowels and examination was unremarkable. As there was no clear diagnosis he was referred to the medical team on call and admitted to Oldchurch Hospital in Romford. I then saw him again and for the last time on 6 August 2003 because he had been refusing to eat and drink and was complaining of a sore throat. Examination confirmed that he possibly had a viral upper respiratory tract infection but his chest was clear but in view of his complex past history he was placed on antibiotics to cover secondary infection and he was encouraged to drink.'*

The advice of my GP Adviser

431 My GP Adviser began by reviewing the evidence regarding the GP's actions contained in the health records:

> *'The GP records demonstrate that the GP's interventions were appropriate as far as they went. Very minimal information was passed to primary care on the discharge summary about the clinical condition and issues surrounding the ongoing and future care of Mark Cannon. As a consequence there was no one document where a GP could look for an accurate summary of Mark Cannon's needs post-discharge.'*

She also said:

> *'There was, however, inadequate information on the discharge summary about the blood loss and consequent anaemia that occurred as a result of surgery and no guidance for the GP or multidisciplinary team about management of the patient post-discharge.'*

432 My GP Adviser noted:

> *'The GP records accurately reflect the medication prescribed in primary care, contacts by telephone between healthcare professionals and contacts with Mark Cannon's family where the GP responded appropriately to family requests for additional medication. The recording of AED (Anti-epileptic drugs) was in accordance with secondary care prescription. No one professional was designated as the co-ordinator of care for Mark Cannon. Apart from communication between the Consultant Neuro-physiologist and*

LD [Learning Disability] *psychiatrist the GP (who probably has the least training and expertise in dealing with complex cases such as Mark Cannon's) was apparently the only healthcare professional to receive letters from other healthcare professionals care specialists about Mark Cannon's ongoing condition.'*

433 My GP Adviser described the picture of Mr Cannon's condition presented in his GP records. She said:

'The GP records reflect an accurate picture of the difficulties experienced in managing Mark Cannon's epilepsy prior to June 2003. There was no problem with the fixation of the fracture or the healing of the wound and there is adequate documentation of secondary care reviews (LD Consultant, Epilepsy Consultant, Orthopaedic Consultant) to the GP during Mark Cannon's first hospitalisation and whilst in the community.'

434 Referring to the GP's visit to Mr Cannon on 6 August 2003, my GP Adviser said:

'[The Learning Disability Consultant] *reviewed Mark Cannon at home* [6 August 2003] *because he was too ill to attend outpatients. He noted that Mark Cannon was very drowsy and dehydrated and advised the parents to call the GP because in his opinion Mr Cannon required IV fluids. The GP visited the same day (time unknown) and examined the patient. A note was made that the patient was refusing to eat or drink, urine was concentrated, pulse was 78, blood pressure 90/60, it was very hot day, and patient was at risk of dehydration. The GP's opinion was that an infection (urinary or chest) was the cause of the problems and antibiotics were prescribed.*

'...

'Although a risk of dehydration was mentioned by the GP no actual mention was made of an assessment of Mr Cannon's hydration or of advising his parents about keeping the patient cool, fluid intake and calling the GP if the patient continued to refuse fluids or stopped passing urine.

'In view of [the Learning Disability Consultant]*'s obvious concern about Mr Cannon's level of hydration the GP could also have taken a blood sample for urea and electrolytes to get a more accurate assessment of the problem. In view of the comment about the environmental temperature it would have been prudent for the GP to arrange to visit or telephone Mr Cannon's parents next day to reassess the patient's condition. There was no mention of such actions in the notes.'*

435 My GP Adviser said that in view of the environmental temperature:

'... the patient's recent medical history should have indicated closer surveillance of the patient and a lower threshold for referral to secondary care.'

Care and treatment by the Practice: the Health Service Ombudsman's findings and conclusion

436 Mr Cannon was discharged from hospital on two occasions with no discharge plan in place. However, on each occasion notice of discharge and brief details were sent to the Practice and a referral was made to the district nursing service.

437 Four days after his first discharge from hospital on 4 July 2003, Mr Cannon's GP organised readmission so that his pain and epilepsy could be controlled and I am advised by my GP Adviser that this was appropriate. Therefore, my findings focus on the care provided to Mr Cannon by the Practice in the period following his second discharge from hospital on 14 July 2003 and, particularly, the days before his readmission to hospital on 10 August 2003.

438 Mr Cannon's mother believes the GP did not act appropriately during this time and should have arranged for her son to be readmitted to hospital. In particular, she believes the GP should have taken this action when he visited Mr Cannon on 6 August 2003.

439 I note that on 6 August 2003 the GP made a home visit at the suggestion of the Learning Disability Consultant who had seen Mr Cannon earlier that day. After he visited Mr Cannon the Learning Disability Consultant had written to the GP setting out his findings and opinion. My GP Adviser said the GP could have taken more account of the information provided by this consultant. However, it is clear to me that the consultant's letter would not have been available to the GP on 6 August 2003 because it was sent to him in the post. Therefore, when the GP visited he would have been unaware of the detail of the Learning Disability Consultant's reasons for suggesting a GP house call.

440 I have seen evidence of the examination performed by the GP to assess Mr Cannon's condition. It is clear that the GP was aware that Mr Cannon might be becoming dehydrated as he recorded his observations that he was not drinking and his urine was concentrated. He also noted that it was a hot day. However, on the basis of his examination and assessment of Mr Cannon, the GP did not consider he was so dehydrated at that point that he required hospital admission. Rather, he diagnosed an infection and prescribed antibiotics.

441 There is no contemporaneous record of any other action which the GP took or any advice which he gave to Mr Cannon's mother at this time, although in his comments to my investigator the GP said he had suggested Mr Cannon should be encouraged to drink.

442 My GP Adviser said the GP's interventions were appropriate, although she thought he could have gone further, perhaps advising Mr Cannon's mother about measures to cool her son. She also suggested that, given the environmental conditions and Mr Cannon's recent medical problems, the GP should have had a 'lower threshold' for monitoring and taking action on his condition. I share the concerns expressed by my GP Adviser. If the GP had acted in line with the principles set out in Once a Day he might have taken a different view or acted differently. It seems to me that, at the least, he should have put in place arrangements to review the situation, perhaps by arranging for a GP to call again, or conducting a telephone consultation the following day.

443 I can understand why Mr Cannon's mother believes the GP should have taken more radical action when he saw her son on 6 August 2003. After all, only a few days later he became extremely ill and was readmitted to the Trust. The judgment I have to make, however, is whether the shortcomings in the service provided by the GP were so serious as to constitute service failure. I have reached the view that they were not. I conclude that shortcomings in the care and treatment provided by the GP **do not amount to service failure**.

444 Therefore, I **do not uphold** Mr Cannon's parents' complaint against the Practice.

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

Complaint (e): the Healthcare Commission's review of Mr Cannon's parents' complaint

445 Mr Cannon's parents are dissatisfied with the way the Healthcare Commission (the Commission) handled their complaint. They say the Commission failed to properly investigate their complaints against the Trust or take appropriate action where they identified serious shortcomings. They also say the Commission's review took too long.

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

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

The Health Service Ombudsman's jurisdiction and role

447 Section 1 of this report sets out the basis of my jurisdiction in relation to complaints made to me that a person (or body) has sustained injustice or hardship in consequence of maladministration by the Commission in the exercise of its complaint handling function.

448 When complaints have already been reviewed by the Commission, I do not normally carry out an investigation of the original complaint, but investigate the way in which the Commission conducted its review. Specifically, I consider whether:

i. there were any flaws in the Commission's review process which makes the decision unsafe;

ii. the Commission's decision at the end of the review process was reasonable; and

iii. whether the service the Commission provided was reasonable and in line with its own service standards.

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

The Health Service Ombudsman's decision

450 For the reasons given below, I **uphold** Mr Cannon's parents' complaint about the Commission's complaint handling. However, I did not consider it appropriate to recommend a further review by the Commission. Therefore, I decided to investigate the complaint myself.

The Commission's review

Key events

451 On 29 July 2005 Mr Cannon's parents complained to the Commission. Their complaint centred on the clinical care their son received during each of his three admissions to hospital.

They said he had suffered an atrocious lack of care and that if even minimal care had been provided they believed he would still be alive. They singled out the lack of nursing supervision in particular as being the fundamental cause of their son's death.

452 In August 2005 the Commission accepted Mr Cannon's parents' complaint for review. The Commission next contacted them in November 2005 when it asked them to complete a consent form. In January 2006 the case was allocated to a Case Manager who contacted Mr Cannon's parents at that point to introduce himself. From that point onwards, they were updated at approximately monthly intervals to inform them of progress with their complaint.

453 The Commission divided Mr Cannon's parents' complaint into 14 issues and sought clinical advice from a registered nurse (the Commission's Nurse Adviser) and a consultant anaesthetist (the Commission's Medical Adviser).

454 The advice provided by the Commission's Medical Adviser consists, for the most part, of a summary of Mr Cannon's medical records with his opinion about the standard of the medical care Mr Cannon received limited to a small number of paragraphs. The Commission's Medical Adviser said:

- his overall opinion on Mr Cannon's first admission was that *'The management of the patient was difficult due to cerebral palsy and pre-existing epilepsy that was not well controlled. All reasonable care was given'*;
- the delay in A&E prior to Mr Cannon's second admission was unacceptable. There was no record of pain or sedation in the admission records. Had the admitting medical staff assessed Mr Cannon's pain in A&E, it could have been assessed and monitored as appropriate; and
- the care Mr Cannon received in the HDU during his third admission was well documented. Despite many attempts to resuscitate him during this admission he died.

455 The Commission's Medical Adviser's overall view of the care and treatment Mr Cannon received was that there were areas for improvement, but he could *'find no evidence that the care was bad'*.

456 The Commission's Nursing Adviser produced a more detailed report. His conclusions included that:

- nursing staff did not provide appropriate care in relation to Mr Cannon's incontinence during his first admission;
- the standard of record keeping during Mr Cannon's first admission was barely adequate;
- the discharge arrangements in respect of Mr Cannon's first admission were inadequate;
- the pain relief given to Mr Cannon during his second admission was inadequate;
- the nursing care during Mr Cannon's third admission was adequate. Nursing staff dealt with a difficult period without adequate information and time fully to appraise themselves of Mr Cannon's condition;
- it was not uncommon for nurses to sleep in a ward kitchen during breaks and it was up to nurses to decide how best to use their break time; and

- staff appeared to lack knowledge and skills in dealing with the special needs of patients with learning disabilities.

The Commission's decision

457 On 20 December 2006 the Commission issued its decision. The Commission referred nine issues back to the Trust for further local resolution because it did not consider the Trust had provided an adequate response and some of the issues raised had not previously been put to the Trust. The Commission upheld Mr Cannon's parents' complaints about:

- the discharge arrangements in respect of Mr Cannon's first admission;
- the delay in A&E prior to Mr Cannon's second admission; and
- inadequate pain relief during his second admission.

458 The Commission made various recommendations including that the Trust:

- audit current record keeping with a view to ensuring patient documentation is completed in line with Nursing and Midwifery Council guidelines;
- review procedures for assessing and recording pain;
- apologise to Mr Cannon's parents for the delay in A&E prior to Mr Cannon's second admission and inform them of the steps being taken to reduce waiting times in A&E; and
- update Mr Cannon's parents on how the Trust ensures practice is accorded with the Valuing People guidance and provide them with information about the steps being taken to ensure the Trust complies with the requirements of the *Disability Discrimination Act 2005*.

459 On 8 January 2007 Mr Cannon's parents wrote to the Commission to express their concerns about the decision. They said they were dismayed at the inattentiveness of the Commission's reading of their account of events. Further, they considered the Commission's decision was unsafe because fundamental times and dates had been inaccurately interpreted and erroneous evidence had been relied upon. They also said they were disturbed that the most crucial aspects of their complaints had not been upheld.

460 On 22 April 2007 the Commission responded to Mr Cannon's parents' concerns. The Commission accepted there had been a number of factual errors, but said this did not affect the overall decision. The Commission said appropriate clinical advice had been taken, all the relevant evidence had been considered, and no further action on its part was necessary.

461 On 13 April 2007 the Trust responded to the Commission's recommendations.

The advice of the Health Service Ombudsman's Professional Advisers

462 I asked my Professional Advisers for their views about the clinical advice which the Commission obtained. My Anaesthetic Adviser said that:

- the advice from the Commission's Medical Adviser was brief, given it had to cover three complicated admissions and it consisted largely of a distillation of events;

- the statement that *'all reasonable care was given'* was not substantiated;
- the delay in Mr Cannon receiving adequate analgesia by the orthopaedic and pain teams was not adequately addressed; and
- the events and possible explanations for Mr Cannon's death during his third admission were summarised but not analysed.

463 My A&E Medical Adviser said that because the Commission did not obtain advice from a consultant with experience of emergency medicine, the care and treatment Mr Cannon received in A&E was not addressed properly.

464 My A&E Nursing Adviser said the Commission's Nursing Adviser presented a detailed report, much of which was appropriate in its criticisms of some areas of the nursing care. She also said the recommendations which the Commission made were relevant and reflected many of the problems encountered by Mr Cannon and his family.

465 However, she said the Commission should have obtained advice from a senior A&E nurse in order to address the episodes of care relating to A&E properly. My A&E Nursing Adviser also said that:

- the Commission's nursing advice did not refer to the delay in A&E prior to Mr Cannon's second admission;
- Mr Cannon's admission to the poorly staffed Receiving Room on his third admission and the care and treatment he received subsequently were not properly addressed;
- she disagreed, fundamentally, with the conclusion reached by the Commission's Nursing Adviser that the care Mr Cannon received during his third admission was reasonable; and
- the Commission's response to Mr Cannon's parents' concern that nurses slept in the ward kitchen during breaks was inadequate because the true issue was overlooked. She said the issue was not whether nursing staff contravened hospital policy in sleeping on their breaks, but whether nursing staff on duty could give safe care to their patients.

The Health Service Ombudsman's findings

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

467 The Commission decided to refer the majority of Mr Cannon's parents' complaints back to the Trust for further action. The Regulations give the Commission the discretion to recommend that an NHS body take further action to resolve a complaint. I agree that, in this case, there was scope for the Trust to investigate matters further and it was not inappropriate that it was given the opportunity to do so. I also note that my Advisers consider the recommendations the Commission made, at this stage, were appropriate and the Trust provided evidence that it had addressed the recommendations. Therefore, I see no basis on which to criticise the Commission's decision to refer the majority of the complaint back to the Trust to resolve and, furthermore, I welcome the fact that the Trust complied with the Commission's recommendations.

468 I am, however, critical of the clinical advice which the Commission took. The Commission may take any advice which is needed to make a decision. I would expect that, when the Commission reviews complaints which involve clinical care, it would obtain appropriate advice from professional advisers with relevant experience and expertise. In reaching its decision, the Commission obtained professional advice from a consultant anaesthetist and registered nurse. They were competent to provide some of the advice required to address the issues raised by Mr Cannon's parents. However, the care and treatment which Mr Cannon received in A&E formed a significant part of this complaint. Therefore, it was necessary to have clinical advice from professionals with relevant experience of A&E. The Commission failed to seek such advice.

469 I find that the clinical advice which the Commission did receive was inadequate. The advice from the Commission's Medical Adviser was particularly poor. That advice was not supported by the available evidence and did no more than provide a brief comment on what were very complex issues. The Commission should not, in my view, have accepted such a superficial clinical report given the complexities of Mr Cannon's clinical care which spanned three hospital episodes. My A&E Nursing Adviser also identified flaws in the Commission's nursing advice. Some of the issues which were central to Mr Cannon's parents' complaint were not covered adequately and the conclusions reached in respect of Mr Cannon's third admission were not, in her view, reasonable in the light of the available evidence.

470 I find that the clinical advice which the Commission obtained was inappropriate and inadequate. This renders its decision unreliable and unsafe.

471 I also find that the Commission's report on its review was not comprehensive, failing as it did to consider key elements of Mr Cannon's parents' complaint, such as the pain relief afforded to their son. The report also contained significant factual inaccuracies which gave them the impression that a robust review had not taken place.

472 Finally, the Commission had the opportunity to put these failings right when Mr Cannon's parents drew attention to the shortcomings in the report. The Commission's response, however, was superficial, incomplete and not evidence-based. I can appreciate why Mr Cannon's parents lost confidence in the Commission's ability to address their legitimate complaints.

473 However, I have not found that the service which the Commission provided was poor. It took the Commission 17 months to complete the review. The Commission's service standard at that time was that, in the majority of cases, the review process should take no longer than six months. Whilst the Commission did not complete its review within this service standard, Mr Cannon's parents had asked the Commission to review a significant number of complex complaints about the care and treatment their son received. I do not consider that, in the circumstances of such a complex and sensitive case, the time the Commission took to complete the review is so unreasonable as to constitute maladministration. In reaching this decision I take account of the fact that the Commission kept Mr Cannon's parents regularly updated about progress with the complaint. One of the six *Principles of Good Administration* (referred to in Section 2 of this report) is that public bodies should be customer focused and, specifically, that they should tell people if things are going to take longer than

they said they would. In their update letters, the Commission apologised for the delay, set out progress on the review and explained when Mr Cannon's parents could expect a further update. This reflects good administrative practice.

474 I conclude that the failings I have identified in the Commission's handling of Mr Cannon's parents' complaint amount to **maladministration**.

Injustice

475 The injustice arising from the Commission's maladministration is that Mr Cannon's parents experienced a further year and a half of uncertainty and distress about the circumstance of their son's illness and death. The Commission's review was conducted without the necessary rigour, and I can understand why Mr Cannon's parents remained dissatisfied when the review was concluded. Maladministration in the Commission's review led to this **unremedied injustice**.

476 Therefore, I **uphold** Mr Cannon's parents' complaint against the Commission.

The Health Service Ombudsman's recommendation

477 **I recommend** that the Commission apologise to Mr Cannon's parents for failing to carry out a proper review of their complaint.

The Commission's response

478 The Chief Executive has accepted my recommendation and she will write to Mr Cannon's parents to express her apologies once the final report has been issued.

Section 4: the Ombudsmen's final comments

Introduction

479 Mr Cannon's parents' overarching complaint is that their son's death was avoidable and that he was treated less favourably for disability related reasons. They told us they have not had full answers to all their questions about their son's care and treatment and they hope our investigation will provide them with those answers. They hope other people will not go through the same experience as their son. In this final section of our report we address Mr Cannon's parents' overarching complaint.

480 In assessing the actions of the Council, the Trust and the Practice we have taken account of relevant legislation and related policy and administrative guidance as described in Section 2 of this report. We have taken account of available evidence and considered the advice of our Professional Advisers.

481 The Local Government Ombudsman has found maladministration in respect of the failure by the Council to provide and/or secure an acceptable standard of care for Mr Cannon and in respect of its complaint handling. The Health Service Ombudsman has found service failure in respect of several aspects of care and treatment provided by the Trust, as well as maladministration in the way the Trust handled Mr Cannon's parents' complaint.

482 We now turn to the issues of whether these failings were for reasons related to Mr Cannon's learning disabilities and whether his death was avoidable.

Was Mr Cannon treated less favourably for reasons related to his learning disabilities?

483 Mr Cannon's parents believe their son was treated less favourably for reasons related to his learning disabilities.

484 In the light of the evidence we have seen, we consider that the Council and the Trust failed to respond to relevant legislation and guidance such as Valuing People, which has been in place for some years before the events complained about. As we have explained in Section 2, this guidance required public services to make reasonable adjustments to ensure that arrangements were in place for appropriate care and treatment of people with learning disabilities.

485 In the light of the evidence she has seen, the Health Service Ombudsman considers that failings in the care and treatment provided by the Trust cannot be separated from the fact that in key areas of care (including pain relief, epilepsy care, assessment and monitoring, and arrangement and provision of support services) staff did not attempt to make reasonable adjustments to the way in which they organised and delivered services to meet Mr Cannon's complex needs. She concludes that in some significant respects the service failures at the Trust were for disability related reasons.

486 In Section 2, we set out our approach to human rights. On that basis, we also conclude that the acts and omissions of the Council and the Trust constituted a failure to live up to human rights principles, especially those of dignity, equality and autonomy. There is no evidence of any positive intention to humiliate or debase Mr Cannon. Nevertheless, by omitting to provide and/or secure proper care for

Mr Cannon public services failed to have due regard to his dignity and status as a person, and to the need to observe the principle of equality.

Was Mr Cannon's death avoidable?

487 Mr Cannon's parents believe that had their son received appropriate and reasonable service from the Council and the Trust his death would have been avoided.

488 In considering whether to make a finding about avoidable death we assess whether the injustice or hardship complained about (in this case Mr Cannon's death) arose in consequence of the service failure and/or maladministration we have identified.

489 The Local Government Ombudsman has found that the Council failed to provide and/or secure an acceptable standard of care for Mr Cannon and that, as a result, his safety was put at risk. The Local Government Ombudsman considers that the accident, from which Mr Cannon suffered a major injury – a broken leg – might well have been avoided.

490 The Health Service Ombudsman has found that after Mr Cannon broke his leg there was a series of serious service failures in his care and treatment by the Trust.

491 Mr Cannon's father is particularly concerned about the events of the night of 10/11 August 2003. He believes that poor care by the Trust on this night played a decisive role in his son's death. He believes that his son breathed vomit into his lungs whilst being nursed on his back without supervision and that this led to the pneumonia which ended his life.

492 The Health Service Ombudsman has concluded that Mr Cannon may have aspirated on that night and this may have resulted in some level of infection in his lungs but she cannot say whether, or to what extent, any infection at this time gave rise to the pneumonia which caused his death.

493 We consider Mr Cannon's death cannot be attributed to one specific incident or action. That said, we conclude that the Council and the Trust failed Mr Cannon. The injury suffered by Mr Cannon might well have been avoided. In any event he should not have died as a consequence of that injury. Our finding is that Mr Cannon's death arose in consequence of the service failure and maladministration which we have identified. We conclude his death was avoidable.

Mr Cannon's parents' response to the Ombudsmen's draft report

494 Mr Cannon's parents welcomed our report saying it was *'tough and hard hitting'*. Nevertheless, they were particularly disappointed that the Health Service Ombudsman did not uphold their complaint against the Practice. They continue to believe their son did not receive a reasonable standard of care from the Practice. In response to Mr Cannon's parents' comments the Health Service Ombudsman asked Dr Owen to review the evidence about the service provided by the Practice. Dr Owen said there were no new clinical matters which had been raised in the response to the draft report which the Health Service Ombudsman should take into account in considering this aspect of the complaint. Therefore, she sees no reason to depart from her findings and conclusions set out in this report.

495 Mr Cannon's father, although welcoming the Health Service Ombudsman's decision to uphold the complaint against the Trust, expressed reservations about some of her findings and conclusions. In particular, he did not agree with specific aspects of her assessment of events of the night of 10/11 August 2003, when he believes Mr Cannon aspirated bile into his lungs. The Health Service Ombudsman asked Mrs Lowson to review the complaint about acute nursing care at the Trust. Mrs Lowson said she had not found any evidence that would cast doubt on the Health Service Ombudsman's findings and conclusions.

496 Mr Cannon's father also expressed concerns about the Health Service Ombudsman's findings regarding the care and treatment his son received in the HDU. In response, the Health Service Ombudsman reviewed the evidence about this period of Mr Cannon's stay at the Trust and sought further professional advice from Dr Skoyles. As a result she provided a more detailed consideration of this aspect of the complaint. This is included in the section of this report which deals with care and treatment at the Trust.

The Ombudsmen's concluding remarks

497 In earlier sections of this, our joint report, we have set out our investigation, findings and conclusions with regard to the care, treatment and service Mr Cannon and his parents received from the Council, the NHS and the Healthcare Commission. We are acutely aware that our findings are likely to cause further distress to Mr Cannon's parents, but we hope we have provided them with the long-awaited responses to their complaints.

498 We also hope our report will provide Mr Cannon's parents with the explanations and answers they sought and that the remedies we have recommended will go some way towards addressing the injustice they and their son suffered. We also hope they will be reassured that as a result of their complaint and our investigation others are less likely to suffer the same experiences as their son.

Ann Abraham
Parliamentary and Health Service Ombudsman

Jerry White
Local Government Ombudsman

March 2009

ANNEX A

Good Medical Practice, 2001: Relevant sections

The duties of a doctor

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

- *make the care of your patient your first concern;*
- *treat every patient politely and considerately;*
- *respect patients' dignity and privacy;*
- *listen to patients and respect their views;*
- *give patients information in a way they can understand;*
- *respect the rights of patients to be fully involved in decisions about their care;*
- *keep your professional knowledge and skills up to date;*
- *recognise the limits of your professional competence;*
- *be honest and trustworthy;*
- *respect and protect confidential information;*
- *make sure that your personal beliefs do not prejudice your patients' care;*
- *act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise;*
- *avoid abusing your position as a doctor; and*
- *work with colleagues in the ways that best serve patients' interests.*

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

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

'Good clinical care must include:

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

In providing care you must:

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

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

Working with colleagues (section 36)

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

- *respect the skills and contributions of your colleagues;*

...

- *communicate effectively with colleagues within and outside the team.'*

ANNEX B

The Third Independent Investigator's conclusions and recommendations

Conclusions

'The first element of Mrs Handley's complaint is that the Council did not provide an appropriate level of care to her son Mark during his stay at the Grange care home.

> *'8.1.2 This element of the complaint is upheld in the light of the findings of* [the First Independent Investigator]*'s report.*
>
> *'8.1.3 That report was written following an investigation that took place shortly after the accident occurred to Mark. The investigation appeared to have been thorough and was, for the most part, carried out while Mark was alive. The shortcomings in practice identified are explicit and evidenced. It is reasonable to assume that the Social Services department accepted the findings of the report because it made it available, on the prompting of the* [second] *independent complaints investigator, to Mrs Handley and to Mr Cannon.*
>
> *'8.1.4 This should not be taken to imply or suggest that Mark's fall occurred as a result of the below standard practices identified. The practices were identified during the course of the investigation of the accident Mark suffered, but the report does not attribute his fall, at some time during the night, to poor practice.*
>
> *'8.1.5 The Council has refused to allow Mrs Handley to progress her complaint to Stage 3 of the statutory complaints procedure.*
>
> *'8.1.6 This element is partly upheld.*

'8.1.7 The reason for this decision is that it was difficult for Mrs Handley to know at what stage of the complaints process she was in. The acknowledgement of her initial complaint in July 2003 indicated that [the First Independent Investigator] *was investigating her complaint, presumably at Stage 1. This acknowledgement rightly advised Mrs Handley that if she were not satisfied with the response she could have the complaint re-investigated by a different officer under Stage 2. It might therefore have been reasonable to assume that* [the Second Independent Investigator] *was engaged to carry out a Stage 2 investigation. However, as Mrs Handley had newly registered her complaint in June 2004, it is possible that* [the Second Independent Investigator] *was acting at Stage 1 in relation to a new complaint. The point is that the stages appear not to have been made explicit.*

'8.1.8 Clearly the investigation which is the subject of this report has explicitly moved the complaint on to Stage 2. The question of moving to Stage 3 would therefore only arise following this current investigation.

'8.2 The department has not acted in a compassionate manner.

'8.2.1 This element is also partly upheld.

'8.2.2 It is upheld in relation to the way that Mrs Handley has been responded to since the inquest into her son's death. The notification that her complaint would not be pursued further is legalistic and abrupt. While the letter to her acknowledges that this is a sensitive issue that "produces significant emotions", the tone of the letter from that point onwards lacks sensitivity. The words "as Mark is deceased, he is not a qualifying individual" are a particular example of this.'

The Third Independent Investigator explained that this aspect of the complaint could not be upheld in full as Mr Cannon's mother had acknowledged that some individuals within the Learning Disability Service had treated her sympathetically and supported her, such as staff at St Bernard's Day Centre.

Recommendations

> *'9.1 The department should accept or reject, in its response to Mrs Handley's complaint, the findings in* [the First Independent Investigator]*'s report concerning the standard of care offered to Mark at the Grange.*
>
> *'9.2 If it accepts the findings it should give Mrs Handley an assurance that* [the First Independent Investigator]*'s recommendations have been acted upon; that procedures and practices have been changed and that monitoring arrangements have been put in place to ensure that the changes continue to be implemented and maintained.*
>
> *'9.3 It should address the measures taken to improve on the shortcomings specifically referred to in* [the First Independent Investigator]*'s report.*
>
> - *Poor communication between staff*
> - *Risk management guidelines not followed*
> - *Inadequate procedures and practices around the management of epilepsy*
> - *Lack of detailed care plans and poor awareness of individual needs*
> - *Poor induction procedures for new staff.*
>
> *'9.4 The department should respond to Mrs Handley's complaint under Stage 2 in the manner prescribed in the department's complaints manual.*
>
> *'9.5 The department should acknowledge to Mrs Handley that its legalistic written response to her, following the outcome of the inquest into her son's death, did appear to be lacking in compassion. While it was no doubt necessary for the Council to make clear its legal position, that could have been tempered by a show of concern for her well-being either through personal contact or in writing.*
>
> *'9.6 In addition to the formal written response to Mrs Handley, in accordance with the complaints procedure, Mrs Handley and Mr Handley should be offered a meeting with a senior manager in the social services department to re-enforce, clarify or explain the substance and import of the written response.'*

ANNEX C

Extracts from the Trust's Director of Nursing and Clinical Governance's investigation and report

Mr Cannon's first admission and the repair of his fractured femur

'Mark Cannon was admitted via Oldchurch A&E on 27 June 2003 with fracture of femur and was admitted to Ward E5 (Orthopaedic). ... Mark's father was concerned about the degree of nursing observation as he was not placed in front of the Nurses' Station; however, Mark's petit mal fits were recorded and following the family's concern, Staff Nurse moved Mark closer to the Nurses' Station.

'Mark had a surgical repair on 28 June. Post-operatively Mark was alert and responsive but distressed. ... Mark's inability to understand the care process led to continued distress over the next few days. Mark's family became distressed and the nursing staff asked the Orthopaedic SHO to reassure the family that care was appropriate.

'Mark's father continued to be dissatisfied with the care; however the record shows adequate recording and care plan. Mark was treated by both physiotherapists and occupational therapists. Sister notes that the Physiotherapist had worked with Mark's mother on movement and transfer. The Occupational Therapist assessed the home environment and the Ward Nursing Staff arranged for District Nurses to care for Mark's wound at home. The Ward Clerk arranged a follow up out patient appointment and posted this. Sending follow up appointments by post is usual practice. Mark was discharged from E5 on 4 July 2003.'

Mr Cannon's second admission

'Mark presented at Oldchurch A&E on 8 July 2003. Mark waited 11 hours for a bed in the Receiving Room (Admissions Ward). Mark was distressed and appeared to be in pain. The Ward Sister in the Receiving Room contacted the Clinical Nurse Specialist for Pain Services on 9 July for advice and support. The medical staff formally referred Mark to the Pain Service on 10 July. Due to vacancies within the Pain Service, the Clinical Nurse Specialist was unable to visit until 11 July. The Clinical Nurse Specialist for Pain Services was concerned about the level of analgesia. She visited Mark three times that day. Pain assessment charts were commenced. The Pain Clinical Nurse Specialist noted that with the exception of the level of analgesia administration, the nurses were giving good care.

'Mark's learning difficulty and difficulty with communication would have led to a degree of disorientation. Allowing Mark the privacy and quiet of a bed away from the main traffic of the ward was a good nursing decision. The Pain Nurse recommended changes to the analgesia prescription verbally and in the medical records. She also spoke to Mark's family. Mark was discharged from the Receiving Room on 14 July.'

Mr Cannon's third admission

The Director of Nursing and Clinical Governance said there were two nurses on duty on 10 August 2003 and described the nursing interventions which took place. She then turned to the specific criticisms made about the overnight staffing arrangements.

'One Staff Nurse then took her break. Due to space constraints, there are no staff rest room facilities on this ward and staff take their breaks in the ward kitchen. Staff are permitted to spend their break however they wish and sleeping during the night break is not a breach of hospital policy. The second Staff Nurse discovered that Mark had passed a large amount of loose faeces. She cleaned Mark with the assistance of his relatives. Whilst she was still at the bedside, Mark vomited a large amount of fluid. The Staff Nurse states that the vomit was projectile and that there was no gurgling or ensuing rattling. She did not observe any change in his condition or vital signs following this episode. She cleaned and settled Mark on his side to prevent aspiration from further vomiting.

'Mark was seen [the following] *morning by the Consultant Physician who decided to transfer him to the Intensive Care Unit. The Consultant Physician discussed Mark's condition with his mother and it was decided not to give cardiopulmonary resuscitation in the event of a cardiac arrest. After the Consultant left the ward, Mark's mother told Sister that Mark's father was not happy with this and wanted CPR to be given. Sister informed the Specialist Registrar of this. Sister noted that there was a difference of opinion between Mark's mother and father about the appropriate course of treatment.*

'At 11.30 Mark's condition deteriorated; his blood pressure became unrecordable and his respirations became laboured. The Specialist Registrar was called and returned to the Ward and a dobutamine (a drug to stimulate the heart muscle) infusion was recommenced to support his cardiac function. Mark was transferred to Intensive Care at 15.00. Mark received active treatment in Intensive Care. Mark's condition stabilised and a decision was taken to transfer him to the High Dependency Unit (B2) on 13 August.'

The events of 14 August 2003

'The Consultant Anaesthetist arrived around 9.00 am but had to attend to another patient first. The consultant examined Mark but was not unduly concerned. He asked for a chest X-ray. Mark was then seen by a Physiotherapist who auscultated (listened for sounds) his chest and agreed with the Sister's findings. It was agreed that Mark should be turned 1 to 2-hourly to improve chest expansion and to give frequent saline nebulisers. At this time Mark remained responsive only to physical stimuli. There was some confusion over the time of Mark's chest X-ray as the radiographer needed to return to the Radiology department to collect extra film to X-ray all the patients. When the exposed X-ray film arrived on HD, the Sister viewed it and immediately called the Consultant Anaesthetist. He viewed the X-ray and decided to intubate Mark and transfer him to Intensive Care for ventilation, however before this was done, Mark suffered a cardiac arrest. Mark was successfully resuscitated and transferred to Intensive Care.

'Mark's condition remained poor and on 28 August, medical staff met the family to outline the seriousness of his condition and poor prognosis and there was agreement to withdraw treatment. Mark Cannon died on 1 September [sic].'

The Trust's overall position on the care provided to Mr Cannon

'CONCLUSION. The admission of any patient to hospital is always distressing but the anxiety and disorientation experienced by a patient with learning difficulties is profound. Mark Cannon was admitted to Oldchurch with a fractured femur. Whilst there could have been improvements in his care, the care documented together with the Nurses statements demonstrate an adequate level of care and planning for discharge. Review by the Orthopaedic Surgeon shows satisfactory care of the wound and review by the Consultant Neurophysiologist shows therapeutic blood drug levels demonstrating that anti-epileptic medication had been administered. There was a brief readmission between 8 and 14 July to stabilise his pain management and there is evidence from the Clinical Nurse Specialist for Pain Services that nursing care was good.

'When Mark was readmitted on 10 August, he was clearly in a very ill state. He was pyrexial, responsive only to physical stimuli, hypotensive and hypoxic. His condition did not deteriorate whilst on the Receiving Room and his nursing there was appropriate. The staff were in regular contact with medical staff and monitoring his vital signs and urine output hourly. The Night Co-ordinator was also involved in assessing his care. The family note some deficits in the care of other patients but the records and the nurses' statements demonstrate satisfactory care.

'Sister from the Receiving Room actively managed Mark the following day and he was appropriately transferred to ITU on 11 August. Mark's illness was clearly a very difficult time for all his family, however Mark's father appeared to have a different view of the treatment that Mark should be receiving and Sister has noted that there was a clear difference of opinion between the parents over his resuscitation status. The Sister on duty in ITU notes that when she transferred him to the High Dependency (B2) on 13 August, she observed that it was a pity to keep moving him but that it was she who transferred him and that she reassured Mark's father that he was stable enough to be moved. The care in the High Dependency Unit was satisfactory and Sister conducted a thorough assessment on the morning of 14 August. This assessment was verified by a separate assessment by the physiotherapist.

'Critically ill patients can deteriorate very rapidly and Mark's respiratory status deteriorated leading to cardiac arrest. He had been assessed that morning by a Nursing Sister, a Chest Physiotherapist and a Consultant Anaesthetist. Following the cardiac arrest, Mark was transferred to Intensive Care where he remained critically ill until the withdrawal of treatment and his death on 29 August.'

ANNEX D

Summary of events relating to the Practice from 4 July to 10 August 2003

4 July 2003
Mr Cannon was discharged from the Trust. A discharge note states that he had undergone surgical repair of a fractured femur and lists his usual medication.

7 July 2003
Note in GP records from a GP saying Mr Cannon is receiving analgesics and antibiotics but is distressed. Diazepam (a sedative) is prescribed.

8 July 2003
The GP made a home visit and recorded that Mr Cannon was more agitated and not sleeping despite the diazepam. He noted that Mr Cannon had passed a loose stool. He examined Mr Cannon and found he did not have a temperature, his fluid level was decreasing and his abdomen was soft. He found no abnormalities in the abdomen or the rectum. He queried the cause of Mr Cannon's symptoms and arranged for admission to the Trust.

14 July 2003
Mr Cannon was discharged from the Trust.

16 July 2003
Note in the GP records of a discussion between a GP and Mr Cannon's mother about pain killers and that later she visited the Practice to ask for sleeping medication for her son. This was prescribed and side-effects explained.

21 July 2003
Letter from an orthopaedic surgeon to the Practice describing his findings and follow-up care arranged (physiotherapy and further clinic appointment) during Mr Cannon's visit to out-patients on 17 July 2003.

24 July 2003
Mr Cannon was seen by a neurophysiologist who advised diazepam should be reduced.

25 July 2003
A community psychiatric nurse from the Learning Disability Service called the Practice to say Mr Cannon needed stronger sleeping tablets. These were prescribed.

28 July 2003
Mr Cannon was seen by his Learning Disability Consultant who wrote a letter to the Practice saying: '*Since the operation he has become agitated, anxious, very moody and can become aggressive towards himself and others. His appetite is poor and he sleeps poorly. He drinks a lot of water and milk*'. He also gave instructions about Mr Cannon's epilepsy medication.

6 August 2003
The Learning Disability Consultant and a learning disability nurse visited Mr Cannon at home because he was too unwell to attend for an appointment. The Consultant wrote to the Practice saying: '[Mr Cannon] *had been refusing food and drinks and appeared very drowsy and dehydrated. I advised that they need to call the GP as he may probably need intravenous fluids*'. This note was sent in the post and would not have been available when the GP visited.

Subsequently, the GP visited. He recorded that Mr Cannon was not eating or drinking and that he was at risk of dehydration. He recorded Mr Cannon's pulse and blood pressure and noted his urine was concentrated. The GP noted that he thought the likely diagnosis was urinary or respiratory tract infection and prescribed antibiotics.

10 August 2003
Mr Cannon was admitted to the Trust.

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