Scottish Parliament Region: North East Scotland

Case 200503536: The Scottish Commission for the Regulation of Care

Summary of Investigation

Category

Scottish Executive and Devolved Administration: The Scottish Commission for the Regulation of Care; Investigation of a complaint.

Overview

The aggrieved (Mrs A) was resident in a Care Home until shortly before her death in hospital in June 2003. Her son (Mr C) complained to the Scottish Commission for the Regulation of Care (the Care Commission) about the care of his mother in the Care Home.

Specific complaint and conclusion

The Scottish Commission for the Regulation of Care failed to properly investigate Mr C's complaint about the care of his mother and in particular the conclusion of their investigation was not borne out by the evidence presented *(upheld).*

Redress and recommendation

The Ombudsman recommends that the Scottish Commission for the Regulation of Care adopt the practice of seeking to agree a statement of complaint which will include reference to the specific matters being investigated.

The Care Commission have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 11 March 2006 the Ombudsman's office received a complaint from Mr C concerning his late mother (Mrs A). Mr C complained that the Scottish Commission for the Regulation of Care (the Care Commission) had failed to properly investigate his complaint about the care of his mother while resident in a care home (the Care Home). The Care Home was subject to regulation and inspection by the Care Commission. Mr C first raised a complaint with the Care Commission on 28 May 2003, prior to his mother's death on 4 June 2003. The initial investigation by the Care Commission did not uphold Mr C's complaint. Mr C appealed against this decision. The Procurator Fiscal's Office also considered the events prior to Mrs A's death and this delayed the Care Commission's further consideration of the complaint. The Care Commission issued a final report on 14 July 2005 which 'partially upheld' the complaint. Mr C did not consider that the evidence gathered and the facts acknowledged in the Care Commission report justified a 'partial' conclusion. Mr C complained to this office that the Care Commission report had not reached a logical conclusion based on the facts.

2. The complaint from Mr C which I investigated is that the Care Commission failed to properly investigate his complaint about the care of his mother in that the conclusion of the investigation was not borne out by the evidence presented.

The Scottish Commission for the Regulation of Care

3. The Care Commission was established in April 2002 as the independent regulator set up under the Regulation of Care (Scotland) Act 2001 (the Act) to regulate care services in Scotland. The Care Commission regulates 15,000 care services including nurseries and care homes. The Care Commission determines whether or not a care service can become a registered care service and the ongoing status of services which are registered. The Scottish Executive has established and published Care Standards which care services must meet. Care Commission staff make routine and unannounced inspections of all registered care services to ensure Care Standards and other regulations issued under the Act are being met. The Care Commission is also responsible for investigating complaints from the public about a care service, and has enforcement powers under the Act to enforce changes or to close a care service. However, in practice, enforcement is

quite rare and staff will usually work with care service providers to improve services.

Investigation

4. Investigation of this complaint involved obtaining and reviewing the correspondence files from the Care Commission and meeting with Mr C and members of his family.

I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Care Commission were given an opportunity to comment on a draft of this report.

Background to the Complaint

5. Mrs A was admitted to the Hospital on 11 May 2003 under the care of Consultant 1. Tests on Mrs A, conducted on her admission to the Hospital, showed a high level of sodium in her blood stream. Mr C told me that Consultant 1 said this was the result of extreme and sustained dehydration through lack of fluids. Mr C also told me that Consultant 1 stated this concentration of sodium in the blood stream had shrunk and damaged Mrs A's brain causing her to lose consciousness. Mr C said that despite Consultant 1's best efforts there was no improvement in Mrs A's condition after two weeks and on 26 May 2003, the family had to take the dreadful decision to remove all support systems. Mrs A sadly died eight days later on 4 June 2003.

History of the Complaint

6. Mr C complained to the Care Commission on May 2003. Care Commission officers conducted an investigation and reported on 25 June 2003. Mr C was not satisfied that the Care Commission had considered all the available evidence or been sufficiently rigorous in their investigation of the evidence provided by the Care Home. Mr C sought a review of the initial decision, in-line with the Care Commission's published Complaints Procedure, on 6 July 2003. Mr C stated that the Care Commission had not considered Consultant 1's diagnosis of Mrs A on her admission and had failed to challenge inconsistencies in the evidence of the Care Home regarding his mother's food and fluid intake in the two weeks prior to her admission to the Hospital. Mr C also complained that the Care Commission staff had not sought his views prior to reaching their decision.

7. Because Mrs A had died suddenly, without specific known cause and after Mr C had raised a complaint about her care in the Care Home, the Procurator Fiscal's office was informed of her death. That office undertook a preliminary investigation prior to preparing a report to Crown Counsel. Crown Counsel ultimately decided not to convene a fatal accident inquiry. It took several months for this decision to be reached and in the meantime the Care Commission suspended investigation of the complaint. At the conclusion of their involvement the Procurator Fiscal's office wrote to the Care Commission confirming the decision not to proceed with a fatal accident inquiry and recommending that the Care Commission now investigate the matter. The letter, dated 12 October 2004, stated:

> '…during the course of my investigation I obtained a precognition from [Consultant 1] of [the Hospital], and I would strongly suggest that he be interviewed as he was able to provide considerable information with regard to [Mrs A's] condition and in particular her extreme dehydration on admission to hospital.'

8. Consultant 1 was interviewed on 9 February 2005 by representatives of the Care Commission. Mr C met with staff on 24 February 2005. The Care Commission issued its final report (the Final Report) on 14 July 2005.

9. The Final Report recorded that the 'Substance of Complaint' as stated by Mr C was that:

> '…on her admission to hospital, [Mrs A] was found to be extremely dehydrated with a Sodium level of 180. You [Mr C] stated that, according to the consultant, this had caused brain damage. You [Mr C] felt that the care staff had contributed to this by neglecting to ensure that [Mrs A] received enough fluids.'

There was no statement of the specific complaint being investigated.

10. The evidence section of the Final Report stated that:

> '[Consultant 1] confirmed that the blood chemistry results of [Mrs A] were the worst he had ever seen, and he had contacted a colleague to discuss his concern. He stated that she was admitted in a very dehydrated state, and

that excluding fluid loss through illness or diuretics, the condition could only be caused by lack of fluids.'

11. The Final Report went on to detail a number of errors and omissions noted in the fluid and food charts as well as the care plans for the Care Home in respect of Mrs A's care. The Final Report also noted that there was no evidence that Care Home staff had communicated their concerns about Mrs A's fluid intake to medical practitioners who had been called in to the Care Home to review Mrs A in light of her deteriorating condition.

12. The Final Report quoted the views of the Care Commission's medical adviser that a diagnosis of dehydration could be missed where, like Mrs A, an individual was taking specific medication for Parkinson's disease. The Final Report also stated that the medical consensus was that dehydration was not a direct cause of Mrs A's death (because she had been hydrated by the Hospital after her admission and was not dehydrated at the time she died). Mr C had disputed with the Procurator Fiscal the connection between the previous dehydration and Mrs A's death but the immediate cause of death did not form part of the complaint to the Care Commission.

13. The Final Report concluded (amongst other things) that:

'It is clear from the review of evidence that [the Care Home] staff did not adequately maintain or record food or fluid intake for [Mrs A]. While accepting the difficulties in diagnosing [Mrs A's] condition by medical staff, there was no clear management of fluids by the care home, which would include how individual needs are assessed, and the monitoring and evaluation of needs. The complaint is, therefore, partially upheld, as it is accepted that medical diagnosis was unclear.'

It is this last statement which caused Mr C to complain to this office as he does not believe it logically flows from all the previous evidence.

14. The Final Report listed four requirements for action by the Care Home within 28 days. The action was required to remedy specific breaches of the Act (or its associated regulations) identified by the investigation.

15. In response to the draft of this report the Care Commission noted that the details of the actions required of the Care Home would not have altered had the decision been taken to fully uphold the complaint as the actions addressed all the agreed deficiencies in Mrs A's care.

Conclusion

16. The Final Report found significant evidence in support of Mr C's contention that Mrs A was severely dehydrated on admission to the hospital and further evidence that staff in the Care Home had failed to take appropriate action to monitor Mrs A's condition or inform medical practitioners. The Final Report also contained evidence that medical staff might have had difficulty in diagnosing Mrs A's dehydration and that it was not the medical view that dehydration was a direct cause of Mrs A's death. I conclude that the Care Commission investigation correctly identified and obtained all the evidence needed to reach a conclusion on Mr C's complaint.

17. However, Mr C was not complaining to the Care Commission about the actions of any medical staff or disputing with them the direct cause of death - indeed these are not matters that the Care Commission has jurisdiction over or can investigate. Mr C was complaining about the alleged inaction of Care Home staff. I consider that the final investigation carried out by Care Commission staff was very thorough and professional and clearly identified and supported a considerable number of Mr C's concerns. However, I consider that the Final Report was flawed because its conclusion was unnecessarily moderated by reference to the disputed medical diagnosis which was not the subject of the complaint.

18. I conclude that the Care Commission failed to properly administer Mr C's complaint in that the investigation correctly identified and obtained all the necessary evidence but failed to reach a logical conclusion on that evidence. I, therefore, uphold the complaint.

19. It is the practice in this office to agree a statement of complaint with the complainant prior to commencing an investigation. While this does not avoid every disagreement it is of assistance in ensuring that all parties, including ourselves, are clear as to which matters are being investigated and which are not. I consider that the disagreement over the direct causes of Mrs A's death and the exact medical

significance of her deterioration prior to death were not matters on which the Care Commission investigation could reach a judgement and as such should not have formed part of any conclusion. This restriction should have been clear from the outset and an early agreement of the precise complaint to be investigated might have helped identify the need for clarification of the scope of the investigation.

20. In response to the draft of this report the Care Commission advised that they had identified that there was a need to clarify the terms of the complaint as part of their complaints procedure. They further advised that they are piloting a range of pre-investigation activities to improve the complaints process, including an agreed written summary of the matters to be investigated.

Recommendation

21. In light of this conclusion the Ombudsman recommends that the Care Commission formally adopt the practice of seeking to agree a statement of complaint which will include reference to the matters to be investigated and recognises that is already forming part of a pilot project.

28 November 2006

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs A	The aggrieved - the complainant's mother
The Care Commission	The Scottish Commission for the Regulation of Care
The Care Home	The Care Home where Mrs A was resident immediately prior to her admission to hospital and shortly before her death
The Hospital	The NHS hospital where Mrs A was admitted on 11 May 2003
Consultant 1	The hospital consultant responsible for Mrs A's care in the Hospital
The Final Report	The investigation report issued by the Care Commission on 14 July 2005
Care Standards	Standards published by the Care Commission under their statutory authority which regulate the actions of care services