Scottish Parliament Region: Central Scotland

Case 200502695: North Lanarkshire Council

Summary of Investigation

Category

Local government: Social work; care in the community

Overview

The complainant (Ms C) raised concerns regarding the care package provided to her sister (Ms A) that was co-ordinated by North Lanarkshire Council (the Council). She believed that the number of hours care was not adequate to meet Ms A's needs, and that care providers were wrong in their view that Ms A could make decisions for herself.

Specific complaint and conclusion

The complaint which has been investigated is that Ms A was not receiving a care package that was adequate for her needs (*not upheld*).

Redress and recommendation

The Ombudsman recommends that the Council and Ms C enter into constructive dialogue to resolve any outstanding issues and to deal with future changes to Ms A's care package, to help all involved understand the issues and gain reassurance about the support being provided. This would, of course, take place only with Ms A's consent in the light of the Council's stated responsibility to give primary consideration to Ms A's needs and wishes.

The Council have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. On 4 January 2006 the Ombudsman received a complaint from a member of the public (Ms C) whose sister (Ms A) received a care package that was co-ordinated by North Lanarkshire Council (the Council). Ms C believed that the number of hours care was not adequate to meet Ms A's needs, and that care providers were wrong in their view that Ms A could make decisions for herself. Ms C submitted a complaint form which was countersigned by Ms A, and I also received consent forms from Ms C, signed by Ms A, to obtain Ms A's medical and social work records.

2. The complaint from Ms C which I have investigated is that Ms A was not receiving a care package that was adequate for her needs.

3. When Ms C presented her complaint to the Ombudsman Ms A was living in a supported housing project operated by a housing association (the Association) and located outwith the Council's area. Ms A was also receiving services from the local NHS Board (the Board). The Association, the Board and the local authority within whose area Ms A was resident (the Neighbouring Council) were all involved in discussion of her care and I have examined documents from all of these organisations in the course of my investigation. However, it is the Council, as the organisation that co-ordinated the funding and delivery of Ms A's care package that has been the subject of the investigation.

Investigation

4. In order to investigate this complaint, I have reviewed documents received from Ms C, as well as correspondence and records requested from the Council, the Board and the Association. I also met with Ms C and spoke to her on the telephone. This was a complex, difficult and emotive complaint, with a large number of documents from a number of service providers covering, in some detail, a seven year period. Therefore, I also sought professional medical advice from the Ombudsman's independent medical adviser (the Adviser) who specialises in mental health.

5. In talking to Ms C during the course of the investigation, I made it clear that my job was to analyse the events that took place at the time she made the complaint, and that we could not enforce changes to Ms A's care package.

6. I very much regret that, for a variety of reasons, the process of considering this complaint has taken much longer than it should have done. For that, I apologise to Ms C, Ms A and the Council.

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

General Background

8. Ms A was born in 1950, the eldest of four sisters. She was diagnosed with a learning disability when she was two years old. Ms C has told me that Ms A experienced a number of difficulties and distressing experiences in her early life including bullying and physical and sexual assault. Between 1973 and 1992 Ms A was resident in a long-stay psychiatric hospital. When Ms A was discharged from that hospital her care became the responsibility of the Council.

Policy Background

9. Ms A's discharge from hospital in 1992 took place in the context of the policy of closing long-stay hospitals and moving care into the community. That policy was given effect by the NHS and Community Care Act 1990 under which the Council became responsible for Ms A's care from 1992.

10. In 2000 the Scottish Executive[1] published a review of learning disability services titled *The same as you?*. In the foreword to the document, the then Deputy Minister for Community Care said:

> 'People with learning disabilities should be able to lead normal lives. We want them to:
>
> - be included, better understood and supported by the communities in which they live;
> - have information about their needs and the services available, so that they can take part, more fully, in decisions about them;
> - be at the centre of decision-making and have more control over their care;
> - have the same opportunities as others to get a job, develop as individuals, spend time with family and friends, enjoy life and get the extra support they need to do this; and

[1] On 3 September 2007 Scottish Ministers formally adopted the title Scottish Government to replace the term Scottish Executive.

- be able to use local services wherever possible and special services if they need them.'

11. A *Statistics Release: Adults with Learning Disabilities Implementation of 'Same as You?' Scotland 2007*, published by the Scottish Government in March 2008, said:

> '*The same as you?* signalled a fundamental change in the way services were provided for adults with learning disabilities. Increasingly services are no longer focussed on buildings, whether in a hospital or Day Centre. People with learning disabilities are now living in the community, often with their own tenancy in a house or small group accommodation. New style day services are being introduced, with a focus on people, and a variety of things to do. More people with learning disabilities are doing activities during the day that are stimulating and include them in the community … All of the local authorities and their NHS and independent sector partners are making progress implementing *The same as you?* Any comparisons between authorities should take account of local prioritisation and varying baseline levels of service.'

Complaint: Ms A was not receiving a care package that was adequate for her needs

12. When Ms C made her complaint to the Ombudsman in a letter of 22 December 2005, she said that she had 'grave concerns' about Ms A, who she said was '… mentally handicapped and also has emotional problems …' Ms C said that the Board had carried out a psychological risk assessment in June 2003 which had indicated Ms A was high risk in three out of four assessment categories (high risk for dangerousness, self-harm/suicide and vulnerability, medium risk for mental instability), and yet the care package Ms A was receiving did not, in her view, meet this high risk. Ms C was also concerned that the Association had started eviction proceedings against Ms A in late 2004, though the action was subsequently dropped '… as it would not look good for them …' The Association were trying to re-house Ms A, but Ms C said that they had offered Ms A:

> '… a pensioners house in a council scheme in the worst drug addled place in [the Neighbouring Council area].'

Ms C said that Ms A had been found unconscious in her flat in August 2005 and was hospitalised with serious health problems, and that hospital nursing staff had been shocked at Ms A's lack of personal hygiene. Ms C said that after

meetings with the Association and the Council, the Council agreed to increase Ms A's care package '… to a few hours in the morning and a few hours in the evening'. Ms C concluded by saying that:

> 'At every meeting I have attended, I have stated that my sister needs 24 hour care, and that she is not able to make effective or even safe decisions about her health and safety. I feel that we have been ignored and patronised and the decisions made by the social work and other agencies have been governed by cost rather than professional assessment of her needs.'

13. In a telephone conversation with Ms C in March 2006 she told me that Ms A had been hospitalised three times in the previous month. Ms C also told me that she and the family had experience of caring for Ms A, but that they were stretched in trying to do so, especially after the death of their father a few weeks beforehand. In a follow-up letter in April 2006, Ms C said that, although Ms A's care package had been increased, it still left her alone from 12:00 to 19:00 and 21:00 to 09:00 each day, and that it had been their father who had looked after Ms A in the afternoons. Ms C also outlined other problems that the family were experiencing, and said that Ms A:

> '… has been hospitalised three times since my father's death with heart and other problems. The [Association] staff have been very helpful with this but again they do not have the hours. [Ms A] has accepted and bonded very well with the new [Association] staff allocated to her in the increased care package and I feel that in view of her recent health problems and the fact that we are under tremendous stress as a family it is important to have her care package increased, and not put into a council flat on her own.'

14. I met with Ms C in June 2006 to talk about her complaint. We discussed her view that the eviction proceedings against Ms A had been dropped as, based on her reading of a Council document, it might not look good for the authorities involved. I suggested that, given the actual wording of the document that discussed the cessation of the eviction action (see Annex 4: 3 February 2005), there was also clearly a concern amongst authority staff for Ms A's wellbeing. Ms C agreed with my analysis of the wording, and said that her version was probably coloured by her view of events. Ms C made it clear that she disagreed with the emphasis given to Ms A's right to choose by the authorities involved. She said that Ms A's capacity to understand and retain information was not good. She said Ms A could retain some information in the

short term, thereby giving the appearance of understanding, but that she would often forget information in a matter of days. She also said that Ms A was impulsive and that, from time to time, Ms A could make things up. Ms C also felt that the diagnosis of a learning disability was insufficient as her sister had complications at birth and had problems with her development as a child.

15. In a telephone conversation with Ms C in November 2006 she told me that Ms A had a new care package, with increased hours, which was helping but she was concerned that if Ms A was put out of Association housing into the Neighbouring Council's housing she would rapidly deteriorate without the support and supervision that the Association offered. She said that, as far as she could tell, Ms A had met with a psychiatrist on a couple of occasions, but Ms C said her strong feeling was that Ms A's history of physical and mental/emotional trauma, had not been fully taken into account by the organisations supporting her. She said that staff persisted in saying that Ms A was 'all right' and that she simply had a mild learning disability.

16. In a telephone conversation with Ms C in October 2007 Ms C told me that Ms A had been offered another house by the Association, just round the corner from her home at the time in the supported housing project. Ms C said that Ms A was going to accept it but that it would mean Ms C buying a lot of new things for Ms A. Ms C also said that Ms A's health had deteriorated due to her obesity and 'lack of care' and that the family were still having to provide much of Ms A's care to the extent that both Ms C and another sister had given up work to look after Ms A.

17. The Council's response to my enquiries stated that they:

> '… have been attempting over a lengthy period of time to engage with [Ms C] and have issued a number of invitations to meet with Social Work Department staff to discuss her concerns. To date there has been no response. The family have had a bereavement during this period and the Local Area Team have been sensitive to those circumstances however given the serious nature of the issues raised in the complaint it was the view of the Area Service Manager that the bereavement did not fully explain [Ms C's] apparent reluctance to meet with staff to offer further detail to substantiate her complaint and to allow her concerns to be explored. The matter has also been the subject of written correspondence with the Mental Welfare Commission (MWC) who in their most recent letter

have acknowledged the significant efforts made by the Council to contact [Ms C].'

The Council's response also stated that:

'… there is an inter agency consensus that the present care plan meets [Ms A's] needs in accordance with the Council's policy and procedures.'

18. The Council also answered specific questions I had put to them. They confirmed that they had statutory obligations of duty and care to Ms A that were established through the NHS and Community Care Act 1990. They explained that the care package for Ms A was initially agreed from hospital discharge through a series of multi-disciplinary meetings between Council, Association and Board staff. From 2003, 25 hours of support per week were agreed and on occasion this was increased when circumstances necessitated. As at April 2008, Ms A was receiving 64 hours of support per week in her own tenancy (ie not in the supported housing project) plus a support team through the Association. The care package was reviewed and managed by Ms A's Social Work Care Manager from the Council (Council Officer 1) on a regular basis through bi-monthly meetings which Ms A could, and did, attend and six-monthly or yearly reviews, a yearly review being a statutory obligation. The Council also stated that they:

'... and partners have appropriately and successfully supported [Ms A] to remain in her own tenancy in her desired location. [Ms A] continues to maintain her current quality of life. [Ms A] engages with all partners and is active in the decision making process and is supported by [her Advocate from a learning disability charity (the Advocate)] … It is important to note that [Ms A] does not wish family involvement in her ongoing care package and arrangements and to date is satisfied with her current care and support arrangements.'

19. I asked the Council for further information on Ms A's apparent wish that Ms C not be involved in her care. The Council informed me that:

'Central to the decision making in the care and support of [Ms A] is [Ms A] herself and she has repeatedly stated that she does not want her sister to be involved in discussions/meetings and she wishes to inform her sister of any information herself (and on most occasions she chooses not to).'

The Council supplied me with statements from Council Officer 1 and the Advocate. Council Officer 1 stated:

'I have been [Ms A's] social worker since October 2003. Those involved in her care and support at that time advised that historically [Ms A] declined any offer of contact from carers to family and I can confirm this. I have carried out numerous home visits to Ms A to monitor and review her care plan during which she advised me she did not want me to contact family and divulge any information about her. At that time she visited her parents regularly (father now deceased) and only informed them of some issues affecting her life but chose which information she wished to share with them. She did not wish her circumstances to be discussed with her sisters and communicated this verbally to myself.'

The Advocate stated:

'… I have been [Ms A's] advocate since 2003. During all of that time it has been my experience that [Ms A] has been quite clear that she does not want the people involved in her care to involve her family in any of her meetings or decision making processes. [Ms A] has always made the decision what to tell her family about her daily life and is most insistent that this is maintained … She has always kept her family separate from her support unless she had something particular that she wanted them to be involved in. In those circumstances she either contacted her family personally or gave her support worker/team leader permission to do so.'

20. The Council also provided me with key documents relating to Ms A's care provision: a document titled Listen to Me!, an Essential Lifestyle Plan (ELP), a Service Specification, a Service Design and a copy of the Association's Support Planning Document for Ms A. The Listen to Me! document, which was undated, was designed to help Ms A think about her life and the things that were important to her, including the people closest to her, the good things about her, her favourite things, her typical week days and weekends and what others needed to do to help her have good days and support her. It is notable that under the 'worst week day' section it was written that Ms A did not like:

'Somebody bossing me – making me do things I don't want to do.'

It is also notable that the people closest to Ms A were recorded as being her family.

21. The ELP was contributed to by a number of people, including Ms C and the Advocate, as well as staff from the Council, the Association and the Board.

The ELP listed the good things people said about Ms A, and it is important to note these:

> 'Nice manners; generous; speaks her mind; thoughtful, cares about others, shows concern for others; remembers details of people's lives; she's a 'polite swearer'; helpful, likes to help others; likes to be involved; likes to feel valued; resourceful; brave; knows what she likes, has her own standards; has a strong sense of justice.'

The ELP also discussed the things that Ms A liked, and the things she needed to feel supported and valued, which in part was an aide–mémoire, almost a script, for support staff, covering supporting her in the morning, to do household chores, to manage her finances, to be healthy and safe, and when she was angry or in a bad mood. The ELP concluded with six unresolved issues:

> 'How do we support [Ms A] in managing anxiety? How do we support [Ms A] in managing her anger? How do we support [Ms A] in ensuring the safety of her property? Would [Ms A] like to have a job – if so how do we support her in doing this? How do we support [Ms A] in having a valued role within her family – who will do this? How do we support [Ms A] in attending the dentist?'

22. The Council advised me that Ms A was unwilling to engage with the Social Work Service to carry out the Community Care Review between 2001 and 2005. They cited records which showed that she was uncooperative with Council Officer 1 at home visits about the review, which was related to her tendency to decline support on occasion (see Annex 4: 26 March 2003). As a consequence the Council were unable to carry out the review. In relation to resolving Ms A's care package, the Council did not consider that there was a delay in resolving this. They cited evidence of working with other services, in particular the Association, and Ms A to find an alternative care provider and increase the hours of the care package (see Annex 4: 19 August 2003, 1 December 2003, 27 January 2004, 1 July 2004, 21 July 2004, 14 February 2005).

23. The Adviser told me that she also found this complaint to be complicated, with a lot of material to work through and assimilate. In relation to Ms A's diagnosis and her capacity to make decisions, the Adviser said:

> '[Ms A] is consistently referred to in the records as having a mild learning disability. [Ms C] contests this, saying that [Ms A] was deprived of oxygen at birth. There is no contradiction between these views – indeed learning

disability results from a congenital defect (ie genetic) or secondary to birth trauma. [Ms C] states that her sister does not have the capacity to make rational judgements about her well being. I would say that there are occasions where [Ms A] may lack capacity, but that overall she appears able to make decisions about her life with support and that she clearly likes to live in her own space, where she can have control over aspects of her life.'

The Adviser said that Ms A:

'… has, in my opinion, complex health and social care needs, which mean that she requires a high level of support in the community. She presents with anti-social and obsessional personality traits, disturbed behaviour including verbal and physical aggression and unstable mood … In my opinion she could be supported to live in the community, and indeed clearly wished to do so, but required more support and active management for her own protection and that of others … I do not agree that [Ms A] needs 24 hour care as in a hospital, although there are clearly times when she does require this and I believe that her care package allows for that at times of crisis. I would however agree that [Ms A] has very high support needs and is probably in the upper category of need in this respect. I can also understand that given what [Ms A] has been through in respect of her community care package, that her family's anxieties would have been lessened by thinking that she was being cared for round the clock.'

24. In relation to the psychological risk assessment, the Adviser said that if the assessment was correct, Ms A would need the highest level of support to live in the community. She also said that she could not determine whether any clear action was taken as a result of the risk assessment. The Adviser noted that it was unclear what the Council were doing to address the problem that the Association could not continue to provide care for Ms A, but neither could any alternative provider, and there was apparent delay in any action being taken. The Adviser's view was that the Association began eviction proceedings against Ms A possibly as an attempt to force the Council's hand. She went on to say that:

'[The Council] clearly had responsibility for [Ms A's] social care needs. I believe that the delay in agreeing a suitable care package for her following [the Association's] statement that they could no longer provide for her care in March 2003 was unacceptable … The consequence of this was that

> [Ms A] was faced with continuing uncertainty about her housing and her future care for several years, and even faced the threat of being evicted from her home, again for some time. As someone with very limited coping strategies, this uncertainty and the anxiety it provoked in her is likely to have contributed to an overall deterioration in her health and behaviour during this time.'

It is also important to note that the Adviser:

> '… formed a very positive opinion of [the Association] and their staff, who appeared to be the ones who had [Ms A's] interests at heart, despite the challenges that she presented …'

In terms of the resolution of Ms A's support, the Adviser concluded that her:

> '… increased care package was agreed and since then her situation appears to have stabilised considerably'.

25. I requested an updated position statement on Ms A's situation from the Council in December 2008. They advised me that Ms A's:

> '… physical health continues to be problematic but has good support from [her current General Practitioner (GP 1)] and carers as required. Due to deterioration in her physical health she requires a ground floor property which was sourced via [the Association]. She was supported by them and the Council to furnish the property which is round the corner from [the supported housing project]. She continues to be supported via staff at [the supported housing project]. [Ms A] coped well with the move and was supported by family and carers and [the Advocate].'

The Council advised me that the Association no longer provided Ms A's care as the supported housing project was now under a new provider, but that the new provider tried to ensure that Ms A was supported by staff she knew who had moved over from the Association. Despite this, not all of the old staff were supporting Ms A and she missed her former care team, though the Council said that Ms A:

> '… accepts the changes – she has been supported by a Health Care Worker and [Psychiatrist 1] and her mental health appears satisfactory at this time.'

Finally, the Council updated me on a recent visit to Ms A:

'[Ms A] continues to require a great deal of encouragement and support to attempt any personal care tasks or household tasks and at present is not going out much at all. An officer from the Council visited her on Wednesday 18 December 2008 and she was chatty. She confirmed [GP 1] had given her a serious talk about her hygiene and skin difficulties. She has agreed with care staff to shower twice weekly. This is the main concern at present but [Ms A] is very clear in making choices and will ask staff to leave her home if she is unhappy with them. All involved in her care and support try where possible to encourage [Ms A] to be as independent as possible and recognise the deterioration in her physical health has impacted greatly on her confidence and ability to carry out some tasks. Staff also respect [Ms A's] right to make choices about her care and support and will when required explain what the consequences may be regarding her decisions.'

Conclusion

26. As noted at the beginning of this report, the number of authorities and individuals involved in one person's support can, at first glance, form a confusing picture for an outside observer. It may form an even more bewildering picture for family members of the person receiving the support, or indeed the supported person themselves. My reading of the evidence is that while, during some periods and on some occasions, the liaison between the bodies could have been better, there was clearly a relationship between the authorities and individuals which was working with the aim of providing suitable support for Ms A. It was also clear that everyone involved – Ms A's family, Council, Association and Board staff, and the Advocate, all had Ms A's best interests and wellbeing at heart.

27. The Council informed me that Ms A stated to the Advocate and Council Officer 1 that she did not want her family, including Ms C, to be involved in decision-making about her (see paragraph 19). This view is also supported elsewhere in the evidence on occasions when Ms A said she did not want family involvement (see paragraphs 18, 19, and Annex 4: 20 April 2004, 5 May 2004, 28 July 2006). In contrast to this, there were also occasions when Ms A was content for information about her to be passed to her family, agreed that her family could become involved in her care, or actively involved them herself (see Annex 4: 23 December 2004, 9 February 2006). There are also times when Ms A received support directly from her family (see paragraph 16 and Annex 4: 15 May 2006). Ms A said in the Listen to Me! document that the

people closest to her were her family (see paragraph 20), and she stated in the Association's Support Planning document that her family were important to her and that she must have regular contact with them (see Annex 4: October 2002). Care Group Meeting minutes of 18 May 2004 noted the view of those attending that Ms A's family were struggling to understand the issues surrounding Ms A's care needs and, therefore, it was clear to them that the family needed support to understand the issues, and that this would be discussed with Ms A (see Annex 4: 18 May 2004). Also, Association Officer 1's view was that the family's expectations were unrealistic (see Annex 4: 10 January 2006). The Adviser's view was that she could understand why the family were anxious, given what Ms A had been through in respect of developing and trying to settle on an appropriate care package (see paragraph 23). The Council said they had tried to engage with Ms C regarding her concerns over a lengthy period of time but she had not responded (see paragraphs 17 and Annex 4: 27 October 2006). It is not uncommon for me to investigate complaints where there are two distinct sides to a story, but this case illustrates that the contrast between both sides is stark indeed.

28. In relation to the care package and the family's view that Ms A needed either residential/long-stay hospital and/or 24 hour care, her nurse therapist (Nurse 1) did express concern that Ms A may need supervision and support imposed on her, and this clearly chimed with Ms C's view (see Annex 4: 30 April 2003). However, other documents on file from the Council and the Board, specifically the judgement of Psychiatrist 1, ruled out any such intervention and the prevailing view was to work within frameworks such as that laid out in *The same as you?* document (see paragraphs 10 and 11). Indeed, the Adviser also said that Ms A did not, in her view, require hospital and/or 24 hour care (see paragraph 23). There was a delay in carrying out a new Community Care Review between November 2001 and February 2005 (see Annex 4: 3 February 2005). However, the Council advised me that Ms A was unwilling to engage with the review (see paragraph 22). Despite this, the Council were able to review and update the ELP, Service Design and Service Specification between 2004 and 2006 to reflect Ms A's needs, views and wishes.

29. The Association clearly voiced their concern for Ms A given the delay in the Council sorting out the alternative provider in March 2003 and the need for the enhanced support package in March 2004 (see Annex 4: 7 March 2003, 12 March 2003, 22 March 2004). The Council have advised that, in their view,

there was no delay in revolving Ms A's care package (see paragraph 22). Ms C in her letter to the MWC said that the family felt Ms A needed 24 hour care and that cost rather than Ms A's needs were dictating the care package (see Annex 4: 17 February 2006). Clearly cost was a factor, as evidenced by an email from a senior development officer at the Council (Council Officer 2) (see Annex 4: 16 March 2004) but there is no evidence to suggest that cost was the overriding factor, and there is considerable evidence to suggest that the authorities concerned were trying to meet Ms A's needs. The cost of Ms A's support was estimated at being between £50,000 and £60,000 per year (see Annex 4: 18 February 2005). The Council have a responsibility to provide care, but also to make the best use of their resources, however, I can see why any focus on cost by the Council might be upsetting for Ms A's family. Ms C was concerned that if Ms A was put out of the Association's supported housing project she would rapidly deteriorate without the supervision that the Association offered (see paragraph 15). But the records show that support was due to increase when Ms A moved into her own tenancy, and much of her support came from visiting Association staff who were not based at the supported housing project (see Annex 4: 1 February 2006).

30. Ms C told me in October 2007 that she and another sister had given up work to look after Ms A because she was not getting adequate care (see paragraph 16). The Council advised me that their understanding was that Ms C and one sister had given up employment to look after another sister who was ill (see paragraph 16 and Annex 4: 11 April 2006). Whatever the case, and in no way do I wish to minimise such a sacrifice, the records show that Ms A was receiving 68 hours per week at that time which the Council, as well as the Adviser, believed was adequate for Ms A's needs. The Council's view was that there was an inter-agency consensus that the care package met Ms A's needs (see paragraph 17). Ms A stated, according to a note written by Psychiatrist 1, that she did not wish 24 hour care but did want someone to talk to in the afternoons (see Annex 4: 23 May 2006). The Adviser was of the view that delays in resolving the problems with finding a care provider for Ms A and in increasing the care package hours were unacceptable, and it appeared to her that the Council took no clear action as a result of the psychological risk assessment (see paragraph 24).

31. In relation to the diagnosis of learning disability and Ms A's capacity to decide for herself, Ms C disagreed with the diagnosis and referred to Ms A's oxygen deprivation as a baby (see Annex 4: June 2003). The Adviser said

there is no contradiction between oxygen deprivation at birth and a learning disability, and that learning disability can result from birth trauma (see paragraph 23). Ms C said, as far as she could tell, Ms A had met with a psychiatrist on a couple of occasions (see paragraph 15), but records show that there were regular meetings between Ms A and Psychiatrist 1. When Ms A was hospitalised in August 2005, her family drew attention to their concerns for her health and about the state of her flat and felt that this contradicted the view of health and social work professionals regarding Ms A's capacity and right to make decisions and choices for herself (see Annex 4: 6 August to 2 September 2005). The minutes of the 16 September 2005 Care Group Meeting recorded that all attending were aware of the family's concerns regarding Ms A's capacity to make decisions for herself, but the minutes also referred to Psychiatrist 1's belief that Ms A had the capacity to make choices (see Annex 4: 16 September 2005). In fact, Psychiatrist 1 was recorded in August 2005 as stating that Ms A had the capacity at that stage in her life to make choices (see Annex 4: 6 August to 2 September 2005). The Adviser said that Ms A, in her view, may lack capacity on occasion, but overall does appear able to make decisions about her life with support, and that she clearly likes to have control over aspects of her life and live in her own space. The Adviser's opinion was that Ms A could be supported to live in the community and did not need 24 hour or hospital care, but did require a high level of support (see paragraph 23).

32. In the Association's Support Planning Document, Ms A said she was strong willed and disliked people telling her what to do and she liked to make her own decisions and be consulted in anything that will affect her life (see Annex 4: October 2002). In the Service Design, Ms A said that she did not like people bossing her around and making her do things she didn't want to do (see paragraph 20). *The same as you?* document made it clear that people with learning disabilities have the right to decide things for themselves (see paragraphs 10 and 11). In line with this, Ms A attended some of the Care Group Meetings and was involved in the development of her care package (see Annex 4: 2 February 2005, 14 February 2005). She was also visited regularly by Council Officer 1.

33. Ms C was understandably concerned that the Association had taken eviction proceedings against Ms A (see paragraph 12) and was unhappy that, in her view, the proceedings had only been stopped because it would look bad for the authorities involved in Ms A's care if they proceeded (see paragraph 14).

The Association mentioned the potential for eviction in March 2004. It was made clear that no one would suggest eviction was a desirable course of action but they had to protect the rights of their other tenants in the supported housing project (see Annex 4: 22 March 2004). So it could be argued that the Council could have avoided the need for eviction proceedings if they had sorted out the care package and the new accommodation more quickly, though I accept the difficulties in finding a new property given Ms A's needs (see paragraph 34). The Community Care Review document of February 2005 noted that it was in no one's interest to pursue eviction as a course of action, as it would be negative for the reputation of the authorities and would be detrimental to Ms A's wellbeing (see Annex 4: 3 February 2005). Ms C characterised the eviction being halted because it would look bad for the authorities but, while this is true in part, it is also clear that the authorities were concerned for Ms A's wellbeing. The notes of a meeting on 3 February 2005, which seemed to form the basis for the Community Care Review of the same date, stated that it would not be in Ms A's best interests to proceed with the eviction (see Annex 4: 3 February 2005). Ms C told Psychiatrist 1 that, speaking to Ms A shortly after she had been served with the eviction notice, she was tearful, thought she would go to prison, and had self-harmed (see Annex 4: 22 December 2004). Ms A told Council Officer 1 two days after receiving the eviction notice that she was a bit anxious about it (see Annex 4: 23 December 2004). It is clear that the serving of the eviction notice had a detrimental effect on Ms A.

34. In relation to the attempts to find a new home for Ms A, the Council had tried to find alterative accommodation for her, though it appears that efforts to do so increased after the eviction notice was served (see Annex 4: 30 December 2004, 8 February 2005). Ms A's family felt that she was being forced to take the first house that was offered to her despite not wanting it (see Annex 4: 28 December 2005), but Council records show that Ms A was assured that she would not be forced to take the house (see Annex 4: 28 December 2005, 1 February 2006). Council Officer 1 was rightly concerned at the Neighbouring Council's view that Ms A could go into homeless accommodation, and it is also understandable that she was frustrated that Ms A's vulnerability did not increase her chances of being allocated a house (see Annex 4: 21 December 2004). The Association prepared a housing specification for Ms A in February 2005 noting what Ms A wanted and needed in terms of type of house and the area she wanted to live in, but they also noted that finding an exact match would be difficult (see Annex 4: February 2005). The Association were clearly taking account of Ms A's needs while balancing

them against the available housing stock. In my view this was a realistic approach for the Council to follow when trying to find alternative accommodation for Ms A.

35. The long-stay psychiatric hospital retraction and closure process was well established by the time Ms C made her complaint (see Annex 4: June 2003). The key points of *The same as you?* document focus on the person with a learning disability being at the centre of decision-making and care, with a move away from buildings to a focus on people (see paragraphs 10 and 11). Although government and health policy forms the backdrop to the origins of this complaint, ie Ms A's discharge from the long-stay psychiatric hospital in 1992 to a community-based delivery of support, it is not my role to question such policy and whether or not people with learning disabilities should be supported in the community or in full-time residential/long-stay care. That is a debate for people with learning disabilities and their families and carers, health and social work professionals, and public policy makers.

36. The Adviser was of the view that the delays in resolving the problems with finding a care provider for Ms A and increasing the care package hours were unacceptable, given the adverse effect it had on Ms A and the distress it caused her family (see paragraph 24). It could also be argued that this situation was precipitated by the Council not taking action on the high risks that were highlighted in the psychological risk assessment. The Service Design from May 2006 and the Council's position statement on Ms A from December 2008 both refer to her worsening physical health (see paragraph 25 and Annex 4: May 2006). My role has not been as a health or social work expert but, as an outside and impartial observer, the deterioration in Ms A's health is a matter of concern, though I understand that she has a history of finding it difficult to attend health appointments and has the right to make her own choices in this regard. However, it is clear that Ms A's family need reassurance that the care package will take account of Ms A's changing needs over time, and I would agree with this.

37. As is apparent from this report and the evidence provided by all parties, this has been a difficult case for all concerned. The documents I have seen do point to delays in relation to finding a care provider for Ms A in 2003, and in getting the funding for increased support hours approved in 2004. The Adviser has been critical of this. Such delays would normally lead to an upheld finding. However, given that the situation was remedied as the Association were, at the

time, confirmed as Ms A's care provider, and the funding for Ms A's care package was secured and she did receive what was regarded as an adequate care package by the professionals concerned and by the Adviser, I do not uphold this complaint.

Recommendation

38. The Ombudsman recommends that the Council and Ms C enter into constructive dialogue to resolve any outstanding issues and to deal with future changes to Ms A's care package, to help all involved understand the issues and gain reassurance about the support being provided. This would, of course, take place only with Ms A's consent in the light of the Council's stated responsibility to give primary consideration to Ms A's needs and wishes.

39. The Council have accepted the recommendation and will act on it accordingly. The Ombudsman asks that the Council notify him when the recommendation has been implemented.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Ms A	The aggrieved, Ms C's sister
The Council	North Lanarkshire Council
The Association	A Housing Association that provided accommodation and support to Ms A
The Board	The local NHS board
The Neighbouring Council	The Council area in which Ms A lived
The Adviser	The Ombudsman's medical adviser, a specialist in mental health
The Advocate	Ms A's independent advocate from a learning disability charity
ELP	Essential Lifestyle Plan
MWC	The Mental Welfare Commission
Council Officer 1	Ms A's Council social work care manager
GP 1	Ms A's general practitioner
Psychiatrist 1	Ms A's psychiatrist
Association Officer 1	The manager of the Association's supported housing project
Nurse 1	Ms A's nurse therapist

Council Officer 2	A senior development officer in the Council's social work department
Council Officer 3	A senior social worker at the Council
Council Officer 4	Ms A's previous Council social work care manager
Association Officer 2	A projects officer at the Association
Psychiatrist 2	Ms A's previous psychiatrist
Nurse 2	A senior nurse at the Board's learning disability service
GP 2	Ms A's previous general practitioner
Council Officer 5	Another senior social worker at the Council
Council Officer 6	Another senior development officer in the Council's social work department
Association Officer 3	A member of staff from the Association
Board Officer 1	Ms A's health care co-ordinator
Association Officer 4	A housing officer from the Association
Association Officer 5	The Association's regional manager
COAD	Chronic obstructive airways disease

Annex 2

Glossary of terms

Atrial fibrillation	The heart has two upper chambers (the left and right atrium, together called the atria) and two lower chambers (the left and right ventricles). Atrial fibrillation is a condition in which the atria contract at a very high rate and in an irregular way, causing a highly irregular pulse rate
Cellulitis	A bacterial infection of the deep layer of skin and the layer of fat and soft tissues that lie underneath the skin. The infection can make skin red, swollen and painful
Chronic Obstructive Airways Disease (COAD)	A lung disease, the main symptom of which is an inability to breathe in and out properly. This is also referred to as airflow obstruction. Airflow obstruction is caused by long-term damage to the lungs, usually as a result of smoking
Hyperthyroidism	Occurs when the thyroid gland is too active and produces an excess of thyroid hormones. This makes the body's functions speed up and leads to symptoms such as shaking, weight loss and anxiety
Pneumonia	Inflammation of the tissues in one or both of the lungs. It is usually caused by an infection. At the end of the airways in the lungs there are clusters of tiny air sacs called alveoli. When someone has pneumonia, these tiny sacs become inflamed and fill up with fluid. The inflammation causes coughing and makes it harder to breathe. It also means the body is

	less able to absorb oxygen
Pleurisy	The pleura are two thin linings that lie between the lungs and the ribcage. Pleurisy happens when these linings are irritated by infection or disease. It is sometimes called pleuritis. It is usually an acute condition and can be easily treated. Symptoms include discomfort around the chest area and breathing difficulties

Annex 3

List of legislation and policies considered

Scottish Public Services Ombudsman Act 2002

NHS and Community Care Act 1990

The same as you? A review of services for people with learning disabilities (Scottish Executive, 2000)

A Statistics Release: Adults with Learning Disabilities Implementation of 'Same as You?' Scotland 2007 (Scottish Government, 2008)

Annex 4

Evidence received to provide detailed chronology

Ms C supplied me with a number of documents, including Council, Association and Board documents she had obtained from Ms A's flat. I made enquires of the Council, the Association and the Board. The Council provided me with extensive correspondence and records about Ms A's care, from the beginning of 2003 to early 2007. The Association's response to me consisted of many documents that had already been provided by Ms C. Association correspondence provided an insight into their relationship with the Council. The Board's response provided me with copies of correspondence, minutes and Ms A's medical records. The medical correspondence supplied by the Board demonstrated that there was regular monitoring of, and contact with, Ms A by Learning Disabilities Service staff. The correspondence and medical notes also gave an insight into various aspects of Ms A's life. I have selected the extracts below as they are relevant to the main report.

11 September 2002

A report on Ms A of 11 September 2002 from a Consultant Clinical Psychologist, as a result of a referral from the Association, noted that:

> '[Ms A] was referred to the Clinical Psychology service on 24 October 2001 by [the manager of the Association's supported housing project (Association Officer 1)]. The referral requested an assessment in relation to the appropriateness of anger management for [Ms A]. This request came following a number of incidents involving [Ms A] becoming aggressive towards members of the local community, staff and causing damage to the property of staff.'

October 2002

Similar to the other planning documents the Association's Support Planning Document for Ms A, dated October 2002, listed the essentials in Ms A's life, as well as likes and dislikes, and things that people supporting her needed to remember. Under essentials it was noted that Ms A:

> '… must have regular contact with my family as they give me a feeling of security.'

This was echoed under the section dealing with Ms A's likes:

> 'My family are also very important to me especially my parents.'

Under her dislikes, it was noted that she disliked:

> '… people telling me or advising me what to do as I am very strong willed and I like to make my own decisions and be consulted in anything that will affect my life. Health care appointments make me very uneasy so I tend to avoid them.'

29 November 2002

The Association were becoming increasingly concerned about Ms A's behaviour and about the delay in the transfer of care from them to another provider. Association Officer 1, in a letter of 29 November 2002 to a senior social worker at the Council (Council Officer 3), said:

> 'The situation surrounding [Ms A] continues to prove unsustainable and has not been helped by the uncertainty of the on/off nature of the transfer of care. Indeed the level of continued disruption being experienced by the entire project is reaching new levels.'

20 December 2002

Association Officer 1 wrote to Ms A's social work care manager at the time (Council Officer 4) on 20 December 2002 to advise that Ms A was continuing to be disruptive and was 'displaying bullying tactics' towards other tenants in the supported housing project. Support staff were also said to have been '… pushed, shouted at, threatened and generally abused'.

2003

There were references in the records from 2003 (January and December) that Ms A could feel suicidal and took non-lethal overdoses of headache and cold remedies with alcohol. The records also showed the ongoing problems there were in trying to find a property for Ms A.

6 February 2003

A letter of 6 February 2003 from a Projects Officer at the Association (Association Officer 2) to Council Officer 3 dealt with the proposed transfer of Ms A's care from the Association to another provider. The Association confirmed that they were due to cease Ms A's care on 16 March 2003 and that the alternative provider had been identified to replace them from 17 March 2003.

7 March 2003

Association Officer 2 wrote to Council Officer 4 on 7 March 2003 when it became apparent at a meeting on that date that the alternative care provider would not be able to undertake all the aspects of Ms A's support that the Association had. Association Officer 2 said:

> 'Given the content of our previous discussions with the Department, this came as a complete surprise to us. As a result of our understanding of the situation until the meeting today, you will be aware that [Ms A] has been told that her support provision will transfer to [the alternative provider] on 17 March, as this is what we believed would be happening. I assume that the Department is now making alternative or supplementary support arrangements for [Ms A] with effect from that date.'

12 March 2003

In a letter of 12 March 2003 from Association Officer 2 to Council Officer 3, he reinforced the Association's concerns about Ms A's support, and that the Council had not yet identified a new care provider. Association Officer 2 said that, in a conversation with one of his colleagues, Council Officer 3:

> '… said that the Social Work Department was not aware of any social care provider which would be able to meet [Ms A's] support needs … Your Department is aware that [Ms A] has already been informed by us, in good faith, that [the alternative provider] will assume responsibility for her support service from 17 March 2003. This understanding was based on meetings which had taken place between July 2002 when [the alternative provider] was finally identified by the Department to provide [Ms A's] support, and Friday 7 March 2003 when [the alternative provider] declared themselves unable to do so. They later claimed at the latter meeting that they had been advising your Department of this for some time … [Ms A] is a vulnerable person who has a learning disability. She has consistently demonstrated her need for appropriate levels of support during the time she [has lived in Association accommodation]. Despite [the alternative provider's] stated inability last Friday to fully support [Ms A], the Department does not appear to have made alternative plans to meet her needs. [Ms A] cannot reasonably be expected to cope with the level of uncertainty which exists around these arrangements.'

To assist Ms A, the Association agreed to extend its support to her on a temporary basis while the Council found a replacement alternative provider.

26 March 2003

Council Officer 4 wrote a briefing report on Ms A. It noted that:

> '[The Association] provide 25 hours a week support, with emphasis on medication management, domestic tasks and budgeting.'

In terms of finding a new care provider for Ms A, Council Officer 4 noted that:

> '… progress has been slow due to [Ms A's] inability to accept regular support. During this time, [the Association] have retained responsibility for medication and budgeting … As it is difficult to identify a provider who can assume responsibility for holding and managing [Ms A's] medication or who can respond to [Ms A's] impromptu requests for support, we have been unable to effect a changeover in service provider. [Council Officer 4] continues to discuss situation … in an effort to resolve difficulties.'

30 April 2003

A letter of 30 April 2003 from Nurse 1 to Council Officer 4 said that Ms A had again been referred to the Clinical Psychology service as she:

> '… had been displaying a number of inappropriate behaviours including verbal and physical aggression to others, and that these behaviours were putting her tenancy at [the Association's supported housing project] in jeopardy … [Ms A] has a mild learning disability and limited impulse control. She has difficulty coping with rejection and uncertainty. She is socially isolated and has no meaningful relationships with anyone other than possibly her parents. [Ms A] has consistently rejected all assistance and support to structure her life and is reluctant to involve herself in any activity. [Ms A] abuses alcohol and nicotine. These will adversely affect her mood and level of anxiety … The issue of where [Ms A] lives and who provides her care needs to be resolved urgently. [Ms A] is not consistently accepting support from her carers and is a danger to herself and others. Therefore support and supervision may need to be imposed on her. You might wish to consider providing her this sort of structure within the framework of the Adults with Incapacity Act.'

30 May 2003

In a letter of 30 May 2003 from Association Officer 1 to Ms A's psychiatrist at the time (Psychiatrist 2), Association Officer 1 outlined that attempts to find a replacement alternative provider had been unsuccessful, as well as expressing concerns about Ms A's behaviour in the supported housing project. The letter said that:

'[Ms A] has involved her family on two occasions about her unhappiness with the service on offer at [the supported housing project] … The family may well want to speak to others about this and despite being supportive of ourselves in the past they have used any difficulties to re-state their historical view that [Ms A] should not have left hospital care.'

June 2003

The psychological risk assessment noted that Ms A had been diagnosed with a mild learning disability, but was not diagnosed as mentally ill or clinically depressed, though it did say that Ms A did sometimes 'get down'. Ms C disagreed with this, stating that Ms A had suffered oxygen deprivation as a baby and her condition was more serious than a mild learning disability. The risk assessment noted that Ms A's current care package (at June 2003) was not meeting her needs. The risk assessment also noted that there was evidence of self-harm, but no evidence of mental instability. Ms C annotated her copy of the risk assessment:

'Total contradiction! Would not self harm if not unstable'

The risk assessment also noted that Ms A had a good relationship with members of her family. Ms C, commenting on the risk assessment, said that it confused Ms A's wants with her needs, and that allowing Ms A control over aspects of her life had led to her hospitalisation. Ms C was sent a copy of the draft risk assessment by the Board on 6 June 2003 and, in the covering letter, was invited to become part of a group set up to discuss and deal with the areas of risk associated with Ms A.

A Board document on the psychological risk assessment gave the background to introducing such an assessment:

'The hospital retraction and closure process has now been underway for over 10 years in Scotland, with a view to all hospitals providing care for individuals with a learning disability closing by 2005. Health care for individuals with a learning disability should be provided as close to home as possible, and should take into account the needs of this population.'

A Senior Nurse at the Board's Learning Disability Service (Nurse 2) advised me that the psychological risk assessment had indeed been completed for Ms A in June 2003.

19 August 2003

By the summer of 2003 the Council had not been able to find an alternative care provider and sought to reach agreement with the Association that they would continue as her permanent provider. Association Officer 2 wrote to Council Officer 3 on 19 August 2003 with a proposal for '… personal support, support with medication, and support with finances to [Ms A]', the core of which was 30 hours per week one-to-one support.

1 September 2003

A report written by Nurse 1 on 1 September 2003 noted that Ms A received 20 hours of support per week from Association staff. Nurse 2 also noted that other providers had tried, and failed, to replace the Association's support as they could not meet Ms A's needs. Nurse 1 concluded her report by saying that:

> '[Ms A] has a history of physical, psychological and sexual abuse and she continues to be taunted by local children. Although close to her parents, she has difficult relations with her sisters at times and may feel she has no definite role within the family. She is anxious over many things, has a low self-esteem and cannot cope with rejection. [Ms A] is angry and socially isolated … I will plan to consult with [Association] staff in an attempt to assist them to help support [Ms A]. Several [Association staff] are already very skilled at supporting [Ms A].'

9 September 2003

A letter of 9 September 2003 from Psychiatrist 2 to Ms A's previous General Practitioner (GP 2) said that:

> '[Ms A] told me that she feels low mainly because she does not like living at [the Association's supported housing project]. She finds the local children and neighbours very difficult to live with. Both care staff and [Ms A's] social worker are aware of this and I have asked that a review meeting be set up to take forward the process of finding [Ms A] somewhere else to live.'

1 December 2003

Association Officer 2 sent a revised care package proposal, with an increase to 64 hours per week one-to-one support, to another senior social worker at the Council (Council Officer 5) on 1 December 2003.

27 January 2004

A meeting between Council and Association Staff on 27 January 2004 agreed in principle on the revised care package proposal, subject to the clarification of some details.

February 2004

The Council's Service Design for Ms A originated in February 2004 (revised in November 2004) was compiled by Council Officer 1 and was contributed to by Ms A, the Advocate, staff from the Council, the Association and the Board. It set out what life was and should be like for Ms A, including where she lived and how she was cared for.

16 March 2004

On 16 March 2004, Council Officer 2 emailed Council Officer 1 about the Association's revised proposal, and said:

> '… we do want to provide this support package – just not at any cost!'

22 March 2004

In a letter of 22 March 2004 from Association Officer 2 to Council Officer 5, he said:

> 'I'm writing to ask whether there has been any progress in terms of the enhanced support package we submitted for [Ms A]. The situation is unsustainable and continues to cause a great deal of difficulty for [Ms A], and her neighbours. As you will recall, it is not only a question of support, but also of location, and we need your help to try to ensure that all possible options are explored … The situation is now critical in terms of [Ms A's] current tenancy, and will reach a stage very soon when formal legal proceedings leading to her eviction will commence. None of us would suggest that this is a desirable course of action, and we would prefer that [Ms A] is supported to live in another tenancy where she wants to be. However, the need to protect the right of others whose quality of life is being markedly affected makes further action inevitable.'

6 April 2004

A note of a telephone call between Council Officer 1 and a Housing Officer at the Neighbouring Council from 6 April 2004 said that the Housing Officer:

> '… advised that [Ms A] has to wait on the same list as everyone else. Explained situation to her and she advised that [Ms A] would go on homeless list if eviction went ahead.'

20 April 2004

Nurse 2 advised me that:

> '… there were discussions as to the relevance of the [psychological risk assessment] at a Care Group Meeting dated 20 April 2004 due to the changing support needs of [Ms A] and alternative options of monitoring the implementation and evaluation of this support package was discussed.'

The minutes from the meeting, which was attended by staff from the Council, the Association, the Board and the Advocate, noted that:

> '[Ms A's] sister contacted [Nurse 1] in February 2004 to raise concerns she had about Ms A. Since this [Ms A] has refused to see [Nurse 1].'

The minutes also noted that:

> 'A service design meeting has been held and a service design is completed and awaiting costing. No house is available for [Ms A] at the moment, although she is on the Council waiting list.'

5 May 2004

A letter of 5 May 2004 from Nurse 1 to Council Officer 1 said:

> 'More recently [Ms A] has stated that she no longer wants my input, and is unhappy that her sister has made telephone contact with me. She has said that she does not want her sister to attend any meeting on her behalf or discuss her care with professionals … At present I don't see anything more I can contribute and I will therefore discharge [Ms A] from my caseload.'

18 May 2004

A Care Group Meeting of 18 May 2004 was attended by staff from the Council, the Association and the Board, as well as the Advocate. The minutes noted that there was:

> 'Some discussion regarding family situation. [Ms A] continues to visit her parents regularly. [The Association] support staff have contacted family when necessary, particularly [Ms A's] sisters. [Ms A's] sisters have concerns about [Ms A] and are struggling to cope and understand the issues surrounding her care needs. [Ms A] on several occasions has informed [Council Officer 1] she did not want contact to be made. [The Advocate] advised the same, although on one occasion [Ms A] had agreed for [the Advocate] to meet her parents but this had fallen through. It is

clear family need support to understand issues and how the planning to support [Ms A] in her own tenancy is progressing. This to be discussed with [Ms A].'

22 June 2004

The Advocate was also concerned about Ms A's situation and wrote to the MWC on 22 June 2004. She said:

'Despite the best efforts of myself, [Council Officer 1] and [the Association], no suitable housing has been identified in her chosen area [in the Neighbouring Council area]. In fact, it has been stated by the housing office that [Ms A] 'will just need to become homeless' and placed in a homeless unit. This situation is completely unacceptable especially when you consider that [the Association] identified the problem two years ago.'

24 June 2004

A Care Group Meeting was held. This was the first meeting that Ms A attended.

1 July 2004

The forms for the funding of the Association's revised support package were signed off by Council Social Work staff on 1 July 2004 and sent to Council Headquarters for approval.

21 July 2004

An internal memorandum written by Council Officer 1 about completing forms for funding Ms A's care package, known as Form A and Form B, noted '… the complexity of supporting this lady'. The intention was to increase Ms A's support hours to 64 per week. Council Officer 1 said:

'However, I foresee some difficulties in sustaining this support as [Ms A] at present does not always accept current support and will not always engage with me and other visitors. This obviously impacts on the support she has now and I feel this may happen when she takes up her new tenancy …'

It was also noted that all those who had supported Ms A:

'… hope that with the increase in hours [Ms A] will have an improved quality of life, risks identified will be reduced and her anxiety levels will decrease, if she accepts the support.'

9 August 2004

The MWC wrote to Council Officer 1 on 9 August 2004 asking for an update on Ms A's situation.

30 August 2004

Council Officer 1 responded to the MWC on 30 August 2004. She said that Ms A's increased hours were awaiting approval at Council Headquarters and that there was a delay in finding appropriate housing for her due to the particular specification of property required, combined with finding such a property in an area Ms A was willing to live in. Council Officer 1 also said that she understood that the Association were due to serve an eviction notice on Ms A, but that:

> 'I would like to reassure you that those involved in supporting [Ms A] are actively working together to ensure that provision of housing and support are appropriate to meet [Ms A's] needs.'

6 September 2004

The MWC wrote to Council Officer 1 on 6 September 2004 asking to be notified when the support funding was approved, and asking for advice on interim accommodation arrangements for Ms A, in the light of the likely eviction notice.

22 October 2004

A Care Group Meeting of 22 October 2004 noted that there has been no progress on finding alternative accommodation for Ms A, and that:

> 'There is also no approved funding at present for [Ms A's] new care package … [Council Officer 1] advised I would be arranging another meeting with [Council Officer 6] to discuss housing and support.'

November 2004

A Service Specification for Ms A was drawn up by the Council in November 2004 (revised in February 2005). It provided information on Ms A's background and set out her support needs. The document noted that:

> 'From lunch-time until mid-evening [Ms A] is completely independent and will go shopping, to the library or take bus trips. From ELP and Service Design it is clear that [Ms A] needs and wants this time on her own.'

21 December 2004

Ms A was served with an eviction notice on 21 December 2004 and on the same day Council Officer 1 telephoned the Neighbouring Council's Housing

Department who advised that Ms A was some way short of the points required for priority housing, and that:

> '… if [Ms A] presents as homeless within 2 months of eviction date they would allocate homeless accommodation … [Council Officer 1] again raised concerns how vulnerable [Ms A] would be in this situation.'

In an email of 21 December 2004 from Council Officer 1 to another senior development officer at the Council (Council Officer 6), Council Officer 1 said the Association had advised her that Ms A had been served with the eviction notice that day. Council Officer 1 also said she had spoken with the Neighbouring Council's Housing Department:

> '… and explained situation again. [I was] advised she is a long way off house allocation and only has 70 points but would need 120. They advised if [Ms A] presents as homeless within 2 months of eviction date then they will allocate homeless accommodation. I again explained the difficulties for [Ms A], her vulnerability and planning that had been done and housing spec but this didn't increase her chances any. Where do I go from here as I feel this whole experience will be detrimental to [Ms A's] well-being.'

22 December 2004

On 22 December 2004 the Association telephoned Council Officer 1 to advise that Ms C had contacted them about the eviction notice and that she was:

> '… very angry with the department at the lack of support she feels [Ms A] has had … [Ms A] wants [Ms C] involved in her planning which has not been the case.'

On the same day Council Officer 2:

> '… suggested that [Council Officer 1] discuss [the Council] as temporary accommodation until something comes up in [the Neighbouring Council]. [Council Officer 2] also advised [Ms A] needs to be made aware of how serious this situation is and that we are doing everything in our power to support her.'

A note of a telephone call between Psychiatrist 1 and Ms C on 22 December 2004 said:

> '[Ms C] is concerned that [Ms A] received a Court Summons writ evicting her from [the Association's supported housing project]. When [Ms C] saw [Ms A] yesterday, she was tearful, thought that she would go to prison,

suicidal and had self harmed. [Ms C] is very concerned that [the Council] have not found an appropriate care package for [Ms A].'

Psychiatrist 1's note went on to detail a telephone call Ms C made to Association Officer 1 on the same day:

'[Association Officer 1] explained that the eviction is not imminent and has spent time with [Ms A] explaining the procedure and planning with [Ms A] for her future. She did make superficial cuts to her arms yesterday but sought help from staff. [Association Officer 1] did not feel that this was any different to [Ms A's] previous self harming behaviour. This is how [Ms A] tends to respond to stressors. He also spent time with [Ms A] planning her support over the next few days and planning her support over Christmas Day. [Association Officer 1] feels that [Ms A] is presenting in much her usual way with no significant changes. We felt a visit from myself at present would cause more stress for [Ms A] and would be counter productive. We have agreed that if the situation changes [Association Officer 1] will contact us and we shall respond as a matter of urgency.'

23 December 2004

On 23 December 2004 Council Officer 1 visited Ms A, who:

'… admitted she was a bit anxious about [eviction] letter she had received. [Council Officer 1] tried to assure her we were doing everything possible to support her to move to a new tenancy. [Ms A] again said she would not consider housing in the [Council area]. [Council Officer 1] spoke to [Ms A] about contesting the eviction notice but [Ms A] was adamant that she did not want to do this even with support. [Council Officer 1] spoke to [Ms A] about her sister [Ms C]. [Ms A] has given permission for me to discuss housing and related issues with [Ms C].'

30 December 2004

In a telephone call on 30 December 2004 between Council Officer 1 and Council Officer 6, Council Officer 6 suggested trying housing associations and private landlords for a tenancy for Ms A, as well as seeking a transfer from the Association's accommodation to the Neighbouring Council's accommodation.

31 December 2004

Council Officer 1 wrote to the Neighbouring Council's Housing Department on 31 December 2004 asking for Ms A's housing application to be considered favourably because of her circumstances.

10 January 2005

In an email of 10 January 2005, Council Officer 1 said to Council Officer 6:

> 'There is no doubt that [Ms A] is a vulnerable person and will be in the community but I also feel she needs her wishes respected.'

12 January 2005

Council Officer 6 responded to Council Officer 1's email of 21 December 2004 on 12 January 2005, saying:

> 'I think we need to be more imaginative about how to support [Ms A] but need [the Association] on board with some ideas.'

20 January 2005

The minutes of a Care Group Meeting of 20 January 2005, attended by the Advocate, Ms A's Heath Care Co-ordinator (Board Officer 1), Council Officer 1, noted that Ms A was spending more money than she was meant to, and that she was:

> '… anxious and agitated regarding current housing situation and therefore this may be her way of coping. [A member of staff at the Association (Association Officer 3)] advised all support would be given to ensure finances are regulated … [Ms A] continues to have contact with parents usually on a daily basis. [Council Officer 1] advised contact had been made with [Ms A's] sister following [Ms A's] permission to do so.

27 January 2005

Council Officer 1 emailed Council Officer 6, in reference to the email of 12 January 2005, on 27 January 2005, saying:

> 'I don't know where to go with this one and my imagination does not appear to be working very well in terms of thinking of a 'looser package' and how this could be managed. The reality is [Ms A] does not have family support or any links and I don't think she would lean towards this.'

28 January 2005

Council Officer 6 responded to Council officer 1's email of 27 January 2005, saying:

> 'The decisions about support need to be made by people as close to [Ms A] as possible … it is harder to change a service and easier to set it up in the best way from the start so people have the right expectations for themselves and [Ms A].'

February 2005

A housing specification for Ms A, prepared by the Association in February 2005, noted Ms A's preferred area, with reasonable proximity to her family, and type of house, which noted ground floor and main door access to cope with her mobility problems and need for privacy. The specification also noted the difficulties in finding available housing stock that met Ms A's needs.

1 February 2005

In a telephone call of 1 February 2005 between the Advocate and Council Officer 1, the Advocate advised that Ms A would now have legal representation in court at her eviction hearing.

2 February 2005

There was an entry in Ms A's medical notes, dated 2 February 2005, that confirmed that Council Officer 1 felt there was no need for further meetings to discuss the psychological risk assessment and there were now Care Group meetings which were smaller and Ms A attended them.

3 February 2005

A meeting was held to discuss Ms A on 3 February 2005, attended by Council and Association staff. A summary of the meeting noted that:

> 'It was agreed that it would not be in [Ms A's] best interests to proceed with eviction and we should plan an alternative course.'

The summary also noted that Council Officer 6 had discussed the agreement to fund Ms A's care with a Social Work Manager and would ask her to sign the paperwork later that day. It was also noted that:

> 'There would be an expectation that the package would be operated flexibly according to [Ms A's] needs. Specifically [Ms A] may not welcome someone overnight in her home but be able to use an on call arrangement to speak to a support worker or have a visit as needed. Unused hours could be 'banked' for holiday support for example.'

A Council Community Care Review document dated 3 February 2005 noted that the last review was on 14 November 2001, and that the next review should be within 12 months if not sooner. The next review was scheduled for 4 May 2005. The review was conducted by Council Officer 1 along with other Council social

work staff as well as staff from the Association, and a meeting of these participants:

> '… was arranged to review the circumstances and to facilitate a course of action that would support [Ms A] appropriately.'

The document noted that given differences between Ms A and her neighbours, surrounding families, other tenants and Association staff, the Association had applied to the court to commence eviction proceedings. However, the document noted that:

> '… it is felt it is in no one's interest to pursue this course of action. It is likely this would result in a negative reputation for all organisations concerned and have a detrimental effect on [Ms A's] wellbeing.'

A Housing Officer from the Association (Association Officer 4) had looked for accommodation for Ms A in the public and private sectors, but with no success, and had rejected the idea of private housing as Ms A:

> '… is very vulnerable and this option would not offer security.'

The document noted that, subject to available funding, Ms A would receive 76 hours of support plus sleepovers per week. It was also noted that the Association would continue to provide support for Ms A, as they had tried to find other providers in the past without success, and any attempt to change care provider:

> '… would be extremely detrimental to [Ms A] at this time. [The Association] are happy to recruit a new staff team for [Ms A] …'

One of the decisions of the review was that Council Officer 6 would get Form A and Form B signed to fund Ms A's care package, and Association Officer 2 would recruit staff for Ms A's support team.

8 February 2005

In a telephone call of 8 February 2005 between Association Officer 4 and Council Officer 1, Association Officer 4 advised that if the Neighbouring Council's Housing Department would send written confirmation that Ms A would be allocated the first appropriate property, the eviction notice could be withdrawn.

14 February 2005

The MWC wrote to Association Officer 2 on 14 February 2005, after the eviction notice had been served, noting the MWC's concern for Ms A's welfare and asking what steps were being put in place to prevent the case from going to court.

The minutes of a Care Group Meeting of 14 February 2005, attended by Ms A, the Advocate, Association Officer 1 and Council Officer 1, noted that there was no further information regarding available housing for Ms A and that the MWC had taken an interest in the Association's eviction proceedings against her. The minutes concluded by stating that Ms A was:

> '… given reassurance that everyone was working towards supporting her in every way possible.'

The minutes also noted that Council Officer 1 advised that Form A and Form B had been signed at Council Headquarters and a copy sent to Association Officer 2.

18 February 2005

In an email of 18 February 2005 to Council Officer 6, Association Officer 2 advised that the annual cost of Ms A's support was likely to be between £50,000 and £60,000.

22 February 2005

A letter of 22 February 2005 from the Association to Council Officer 1 confirmed that, as the Council had committed to find additional support hours for Ms A, and because the Association were hopeful that the Neighbouring Council would help to find Ms A a tenancy, they had withdrawn the eviction case from court.

23 February 2005

At a meeting on 23 February 2005 attended by Council Officer 1 and Council Officer 5, the Advocate, Association staff and Neighbouring Council Housing Department staff, it was noted that the eviction notice was being withdrawn and that all present would work in partnership to ensure that Ms A was re-housed in the most appropriate area and type of housing.

25 February 2005

Council Officer 6 responded to Association Officer 2's email of 18 February 2005 on 25 February 2005, saying:

'I do appreciate all your efforts to reach a mutually satisfactory outcome quickly for [Ms A]. There is nothing I would like better.'

21 July 2005

A letter of 21 July 2005 from Psychiatrist 1 to GP 2 said:

'I understand that [Ms A] has a new staff team in place, and that this is generally going well for her. As usual, she continues to express the wish to find a new home, and I believe social work are looking into this with her.'

1 August 2005

A Care Group Meeting of 1 August 2005 noted that Ms A had:

'2 workers at present and [Ms A] is getting on very well with both. Possible new worker starting soon. [Council Officer 1] requested notification prior to worker commencing as another Form A requires to be completed and signed.'

6 August to 2 September 2005

The Council's records noted that Ms A was in hospital from 6 August 2005 until 19 August 2005. She was admitted after being found unconscious in her flat, and was diagnosed as having a chest infection and pneumonia. While in hospital Ms A's family expressed concerns about the level of support she was receiving and the cleanliness and tidiness of her flat. In a telephone call of 17 August 2005 between Association Officer 1 and Council Officer 1, Association Officer 1 said that:

'… [Ms A] had telephoned today and was quite agitated because her sisters are telling her she is not going back to her flat until it is decorated and new furniture.'

In a separate telephone conversation on the same day between a staff nurse at the hospital and Council Officer 1, the staff nurse:

'… advised that she had spoken to [Ms A's] sister and that she is fit for discharge but family are saying she is not going back to the house due to the state of it.'

The following day there was a meeting between Ms C, Council Officer 1, Council Officer 5, Association Officer 1, and Board Officer 1 to discuss the family's concerns about Ms A and her environment. The record notes that '… agreements have been reached …' but did not specify what those agreements were. A Council record of 19 August 2005 noted that Psychiatrist 1:

'… confirmed [Ms A] does have capacity at this stage in her life to make choices.'

The records also noted that Ms A had been admitted to hospital again on 29 August 2005 so that intravenous antibiotics could be administered to treat cellulitis in her legs. She was discharged on 2 September 2005.

5 September 2005

In a telephone call of 5 September 2005 Ms C repeated her concerns about Ms A's welfare and support to Council Officer 1. The following day, Association Officer 3 advised Council Officer 1 in a telephone call that:

'… [Ms A] was being very difficult and not willing to do anything for herself. This includes walking to the toilet and she is wetting herself on the couch and apparently saying that [Ms C] told her not to do anything for herself. Also phoning unit every 10 minutes looking for company and reassurance.'

16 September 2005

A Care Group Meeting on 16 September 2005 was attended by staff from the Council, the Association and the Board, as well as the Advocate. The minutes noted Ms A's recent four admissions to hospital and the concerns for her health. The minutes also noted that there was a discussion about Ms A's capacity to decide things for herself:

'All at meeting aware of family's concerns regarding [Ms A's] capacity to make decisions for herself. [Board Officer 1] advised that this had been discussed with [Psychiatrist 1] who believes [Ms A] has capacity to make choices.'

The minutes also noted an issue regarding Ms A's finances, that Ms A had made over 1500 telephone calls in three weeks to family members of support staff, running up a £130 bill. In terms of Ms A's support hours, the minutes noted there was a:

'Discussion about increase in hours but both [Association Officer 1] and [Association Officer 3] advised they do not have the capacity to staff extra hours at present. Interviews will be held next week as it is hoped that some can be recruited for [Ms A's] team.'

Finally, Ms A's support hours, broken down by day, were noted, as was the fact that her family visited regularly.

13 October 2005

A letter of 13 October 2005 from Psychiatrist 1 to GP 2 said:

> '[Ms A's] mood was appropriately reactive, she became low when discussing the lack of progress on her new house, and bright when discussing her cat or recent outings that she had to her parents.'

2 November 2005

A Council record of 2 November 2005 noted that Ms A had run up a telephone bill for over £200 in the past month.

9 December 2005

Another Council Community Care Review was conducted on 9 December 2005. The document noted that since the last review:

> '… the eviction notice was removed with an agreement that alternative accommodation be sought as a matter of urgency … Housing specification has been reviewed regarding [Ms A's] needs and the areas she would want to stay and be safe. [Association Officer 4] spoke to [Ms A] about this.'

It also noted that, in terms of decisions made at the last review, Form A and Form B had been signed at Council Headquarters, and that support staff for Ms A had been recruited but additional staff were still required. A decision from this meeting was that Council Social Work staff would complete more forms regarding the increase in Ms A's hours.

28 December 2005

A Council record of 28 December 2005 noted that Ms A had been offered a property she did not like in an area where she did not want to live, and had become anxious and agitated, and her family were angry with the offer. Council Officer 1 spoke to Association staff that day:

> '… who confirmed [Ms A] was clearly stating that she did not want that house, [Council Officer 1] advised [Ms A] would not be forced to take the house.'

10 January 2006

In a telephone call of 10 January 2006, Association Officer 1 advised Council Officer 1 that he had a difficult conversation with Ms A's family and his view was that they were being unrealistic in their expectations.

20 January 2006
Ms C complained to the Association on 20 January 2006.

1 February 2006
Ms C and her cousin (a Local Councillor at the time) went to a meeting on 1 February 2006 that was attended by staff from the Council, the Association and the Board. She took her own record of the meeting, which noted that the family were not happy with the group's decision to put Ms A in a house without 24 hour care. They also raised the issue of the eviction notice which they felt showed that Association staff could not cope with Ms A. Ms C's record also noted Psychiatrist 1:

> '… stated that [Ms A] 'was fine' and would be able to cope and did not see the need for Public Guardianship, despite classing her 'high risk' in her report. My family find that her view is astonishing in view of her profession.'

Ms C's record went on to say:

> 'Family present raised concerns of sister's health since leaving [the long-stay psychiatric hospital], lack of integration into community even clubs etc for disabled and also [concerns about Ms A's personal hygiene and cleanliness of her home]. [Council Officer 5] said that it was my sister's 'choice' not to go to Doctor or wash or go to dentist or eat properly. Family present contests this as sister is brain damaged and is not able 'to make safe or effective decisions for herself'. Social work will not commit to 24 hour care or public guardianship again using excuse that sister had said she did not want it. Family also contest this. [Council Officer 5] is confusing needs with wants, a very cost effective way of looking at it. Family felt that we were being stonewalled by all above agencies.'

The Council minutes of the meeting about Ms A on 1 February 2006 recorded that it was attended by staff from the Council, the Association, the Board, and the Advocate. The meeting was also attended by Ms C and Ms A's cousin and they took their own note of the meeting (see above). The Council's minutes noted that the Council Officer 5:

> '… gave overview of current situation for [Ms A] and confirmed with [Ms C] the family's concerns regarding [Ms A's] capacity to make safe and effective decisions regarding herself.'

The minutes also noted that Psychiatrist 1 was:

'… aware that [Ms A's] mental health varies and that this presents itself in challenging behaviours and self harm … [Psychiatrist 1] reiterated the importance of monitoring [Ms A's] mental health as there is the potential for this to break down, but no concerns presently.'

Ms C asked how Ms A was monitored, and she was told that this was done by Association staff and Board Officer 1 who visited her weekly. The minute went on to note that Ms C:

'… questioned the fact that Health Professionals believe [Ms A] has capacity to make safe and effective decisions as family feel this is not the case … '

Ms C also raised concerns about Ms A's physical health and hospitalisation, and an:

'Explanation given that [Ms A] does not always accept support to attend any medical appointments and staff at [the Association] have often requested a domiciliary visit to ensure [Ms A] is seen by appropriate medical professional.'

There was also discussion of a 'Part 5', relating to Part 5 of the Adults with Incapacity (Scotland) Act 2000. The minutes explained that:

'A Part 5 allows for the medical treatment of people who are unable to consent to treatment. However, as [Ms A] can make decisions for herself regarding medical treatment it was felt this would not be beneficial. Family did not agree with this and feel [Ms A] only takes medication when administered by support staff. Confirmation that this is the case but [Ms A] will always have support to take medication that has been prescribed. Ms C explained that when [Ms A] was in [the long-stay psychiatric hospital] she was looked after and there were no risks and family feel strongly that this is what [Ms A] requires. [Council Officer 5] explained that there are no longer long-stay hospitals or residential establishments as these are closing and people are now being supported in community settings.'

Ms A's cousin raised concerns about her health and hospitalisation, and the minutes noted that the:

'Family felt there were not enough hours of support for [Ms A] and that she would not have been found on the floor had she had continual support. [Council Officer 1] advised that [Ms A] does not want carers in her home all the time and this had been discussed with her on many occasions.'

Staff from the Association confirmed that Ms A's support levels at the time were 25 hours from staff based in the supported housing project plus 32 hours from visiting Association staff. It was also noted that a further increase in hours was anticipated when a new home was found for Ms A. Ms C felt that Ms A's Association support workers were very good and had managed to develop a good relationship with Ms A. In relation to Ms A's housing situation, including the house that Ms A had recently viewed (see paragraph 10):

> '[Association Officer 4] confirmed that [Ms A] was excited about possible move and was eager to see the house on offer which had come up unexpectedly. [Association Officer 4] advised [Ms A's] decision not to take the house was respected and she would not be pressurised into taking it. [Ms C] advised [Ms A] had been very upset and told family she was being made to take the house which family felt was in a deprived area and not suitable as it was all elderly people. [Association Officer 4] advised that [the Neighbouring Council and the Association] are working closely together to ensure appropriate alternative accommodation is achieved for [Ms A].'

9 February 2006

In a telephone conversation of 9 February 2006, Association Officer 3 advised Council Officer 1 that:

> '… they have spoken to [Ms A] regarding maintaining contact with family. [Ms A] has agreed to [Association Officer 3] contacting [Ms C] weekly to update and allay any concerns they may have.'

17 February 2006

Ms C wrote to the MWC on 17 February 2006 asking them to look into Ms A's situation. In her letter Ms C made it clear that:

> 'My family feel that my sister needs 24 hour care … We feel that cost rather than my sisters true needs are dictating the care package.'

20 February 2006

The Association's Regional Manager (Association Officer 5) responded to Ms C's complaint of 20 January 2006 on 20 February 2006. He provided an explanation of Ms A's health condition that led to her hospitalisation in August 2005, and in relation to her personal hygiene, he said that Ms A's:

> '… compliance levels in accepting support with personal and domestic hygiene is variable. We can not impose support. As I stated at [Ms A's]

meeting this would be tantamount to assault and would potentially erode what can be an extremely fragile relationship.'

Association Officer 5 went on to talk about Ms A's housing situation, saying that:

'This has been the subject of considerable dialogue with [Ms A], yourselves, Social Work, Health, Housing and [the Association]. It is significant that [Ms A] is consistently now stating, as evidenced by [the Advocate], her wish to live elsewhere than [the supported housing project]. It is also noteworthy that, notwithstanding specific health issues, [Ms A] has been relatively settled since establishing the commitment to seek alternate accommodation. The increase in support levels, I believe, has contributed to this. Support levels will also increase further once alternative accommodation is secured for [Ms A]. The progression of this matter has been slow. However, all parties are committed to meet [Ms A's] housing and support aspirations. This may take some time. [The Association] will continue to engage with local housing providers in order to progress this. There is no doubt that, regardless of where [Ms A] ends up living, she will require continued support and that this will be provided. If the housing and support is provided on [Ms A's] terms it would be hoped that this would result in a significant improvement in [Ms A's] welfare and quality of life.'

28 February 2006

The Council records noted that Ms A's father died on 28 February 2006 and that according to Association staff she was very upset.

2 March 2006

In a letter of 2 March 2006 to GP 2, Psychiatrist 1 advised that Ms A was in the initial stages of bereavement following the death of her father, displaying shock and disbelief, but that her support workers felt that she was managing well given the circumstances. Psychiatrist 1 also confirmed this to Council Officer 1 in a telephone call on the same day.

24 March 2006

Council Officer 1 visited Ms A on 24 March 2006 and noted that Ms A had been admitted to, and discharged from, hospital in the past week with an irregular heartbeat. Council Officer 1 also noted that Ms A was able to talk about her father's death, that she had coped well with the funeral, and that she was visiting her mother regularly.

11 April 2006

A Care Group Meeting on 11 April 2006 was attended by staff from the Council, the Association and the Board, as well as the Advocate. The minutes noted a deterioration in Ms A's health since her hospital admissions in August 2005, and:

> 'All agreed it is unlikely that [Ms A's] health will improve due to her lifestyle and smoking and therefore she requires a robust health support system.'

The minutes also noted that Ms A was agitated and anxious, the cause of which appeared to be family related due to her father's death and the break-up of a family member's marriage, and the same family member was suffering from a degenerative illness.

26 April 2006

In a visit to Ms A on 26 April 2006, Council Officer 1 noted that Ms A appeared positive in discussion on waiting for a new property, although she was feeling generally unwell and still making a lot of short telephone calls, 70 per day on average.

May 2006

The Service Design was revised again in May 2006, ruled out a residential/long-stay care setting in favour of supported living, and noted that:

> '[Ms A] does not wish to share with anyone, Likes her own privacy and space, Likes to do things her own way. A place of her own.'

The Service Design noted how Ms A might spend her days, and that she was receiving 68 hours of support per week. It also noted that Ms A was continually contacting her family, especially her sisters, by mobile telephone. In relation to Ms A's health, the Service Design said:

> 'Due to physical health deterioration [Ms A] appears to have lost confidence in herself which has impacted greatly on her independence. [Ms A] lacks motivation and requires constant encouragement with all daily tasks and with any activities she may show an interest in.'

15 May 2006

A Care Group Meeting on 15 May 2006 was attended by staff from the Council, the Association and the Board. The minutes noted that Ms A continued to have physical health problems, but had changed from GP 2 to GP 1. Ms A was said

to be coping well mentally with her poor physical health and the death of her father, although she was showing signs of mild depression. Her shower was not appropriate for her needs, which was causing personal hygiene problems, but it was noted that Ms C was helping Ms A to use their mother's shower, and that Board Officer 1 and Council Officer 1 would try to get a new shower fitted for Ms A. Ms A was receiving 64 hours of support per week from the Association, but Association staff:

> '… advised that [Ms A] seems to expect staff to do everything for her saying that's what they are there for. Staff continually striving to promote [Ms A's] independence as much as possible … [Ms A] has always expected staff to do tasks for her and can be very demanding. Staff agreed that [Ms A's] mood has improved but she requires some interests.'

23 May 2006

A note written by Psychiatrist 1 on 23 May 2006 said:

> '[Ms A] feels she is getting on well with new staff. Would like someone to talk to in the afternoon but does not wish 24 hour care.'

9 June 2006

Council Officer 1's visit to Ms A on 9 June 2006 was generally positive, and it was noted that:

> '[Ms A] fine and advised she was feeling better. No concerns at this time and happy with care team.'

22 June 2006

On 22 June 2006 the Council records noted that Ms A had visited GP 1 as there had been a recurrence of a chest infection and cellulitis.

28 June 2006

A Care Group meeting on 28 June 2006 was attended by staff from the Council, the Association and the Board, as well as the Advocate. The minutes noted that Ms A still had physical health problems which were affecting her mobility, and that, while her mood was low, she was less volatile than previously and was more accepting of support from Association and Board staff.

19 July 2006

Ms A was admitted to hospital on 19 July 2006 with possibly pleurisy and a severe chest infection. She was discharged from hospital on 23 July 2006.

28 July 2006

On 28 July 2006 Council Officer 1 spoke to Association Officer 1:

> '… who advised he had spoken to [Ms A] again about her finances as apparently [Ms C] had spoken to [Ms A] about taxis everywhere and that she can't afford to travel this way. [Ms A] said [Ms C] was going to look after her finances but [Ms A] has told her she doesn't want this.'

10 August 2006

A letter of 10 August 2006 from Psychiatrist 1 to GP 1 said:

> '[Ms A] felt that she was doing 'okay' despite a recent admission to [the local hospital] with an exacerbation of [chronic obstructive airways disease or COAD] and a new diagnosis of hyperthyroidism. [Ms A's] carers concur that [Ms A's] mood is brighter and her sleep has improved … [Ms A] continues to do well from the point of view of her mental health, with improvements in mood, sleep and enjoyment.'

11 August 2006

At a visit by Council Officer 1 on 11 August 2006, Ms A said she was fine and feeling better and visiting her mother regularly.

6 September 2006

In a telephone call of 6 September 2006, Association staff advised Council Officer 1 that Ms A had visited GP 1 due to another chest infection.

21 September 2006

A letter of 21 September 2006 from Psychiatrist 1 to GP 1 said:

> 'We discussed recent changes in [Ms A's] staff team, and this resulted in [Ms A] feeling more agitated than usual. That said [Ms A] feels that she is coping with the gaps in her support being filled with other members of staff … She continues to go out to the bank and to visit her mother but doesn't have many other social opportunities … She is currently managing well given her recent stressors and is able to link her agitation to changes in her care team.'

27 September 2006

Another Council Community Care Review was conducted on 9 December 2005. The document noted that, in terms of decisions made at the last review, a Form B had been completed regarding Ms A's support package.

4 October 2006

A note written by Psychiatrist 1 on 4 October 2006 said that, after disruption to her care team had been resolved, Ms A:

> 'No longer feels agitated and is happy with the support she receives. No issues from carers.'

27 October 2006

On 27 October 2006, Council Officer 5 told Council Officer 1 that she had advised the MWC:

> '... that we had been unable to follow up allegations/complaints made by [Ms C] as she had not responded to a number of letters etc over recent months.'

10 November 2006

A Care Group Meeting on 10 November 2006 was attended by staff from the Association and the Board, as well as the Advocate. The minutes noted that Ms A's physical health was still poor, there were ongoing problems getting a replacement shower for Ms A, and that she was more agitated than previously. An Occupational Therapist:

> '… had suggested bereavement counselling for [Ms A]. [Psychiatrist 1] had said that this had been suggested in the past but that [Ms A] was not open to the idea – if [Ms A] was receptive to this now, then it could be beneficial.'

13 December 2006

In a telephone conversation of 13 December 2006, Association Staff advised Council Officer 1 that Ms A had been admitted to hospital and that the cause appeared to be 'heart failure'. The Association also advised that:

> '… the issues which led to possible eviction (which was withdrawn) and looking for a planned move for [Ms A] are not apparent any more and therefore [Ms A] does not need to leave the [supported housing project]. They appreciate that [Ms A's] physical health is deteriorating and her mobility is poor therefore a ground floor property would be beneficial.'

21 December 2006

In a telephone conversation of 21 December 2006, Association Officer 1 advised Council Officer 1 that GP 1 had diagnosed another chest infection.

A letter of 21 December 2006 from Psychiatrist 1 to GP 1 said:

'I understand [Ms A]'s physical health has recently caused her problems with an admission to [the local hospital] for 'an irregular heartbeat' and also another chest infection, which was diagnosed this week. [Ms A] told me she was fed up today, she historically finds the Christmas period very difficult and this is compounded by the fact that today would have been her late father's birthday … [Ms A's] presentation is characteristic of her usual presentation at this time of year. I have discussed this with staff and the need for [Ms A] to be supported, as they have been doing.'

24 January 2007

A Care Group Meeting of 24 January 2007 was attended by staff from the Council, the Association and the Board, as well as the Advocate. The minutes noted:

'… [Ms A's] physical health and the significant deterioration that has taken place over the past 2 years. [Ms A] was admitted to hospital in December and this was due to heart failure. She also suffers recurring chest infections for which antibiotics are required. [Ms A] also had an infection in her groin area that also required treatment from [GP 1].'

Despite this, Ms A's mental health was noted as being good and that Ms A appeared to be settled. With regard to the shower:

'[Ms A] has not had a shower for many months and only gets a wash down sitting in the living room. This is not appropriate as [Ms A] has a groin infection and also cellulitis and requires good personal hygiene.'

It was noted that there was a delay relating to a detailed occupational health assessment, and both Council Officer 1 and Board Officer 1 agreed to write to the Occupational Health department to try to progress the matter. It was also noted that Ms A had started visiting her mother every day, which she used to do previously.

1 February 2007

Council Officer 1 telephoned the Association on 1 February 2007 for confirmation of Ms A's support hours, and was advised that it was 68 hours per week at that time.

2 February 2007

A letter of 2 February 2007 from Psychiatrist 1 to GP 1 said:

'[Ms A] has a mild learning disability and a depressive disorder from which she is recovering. As you are aware, she also suffers from atrial fibrillation and [COAD]. Currently [Ms A] is doing well, with no concerns from her carers. I understand her mood has been low for the past two to three days, however she was unable to identify a reason for that. [Ms A's] mood has again begun to lift. She feels her general health is a bit better at present … [Ms A] continues to do reasonably well at present and is accepting of and working with her new support team. She has little in the way of social opportunities, however is not keen to pursue this.'

5 March 2007

A Care Group Meeting on 5 March 2007 was attended by staff from the Council, the Association and the Board, as well as the Advocate. The minutes noted that Ms A's health was still poor and she was still not willing to attend health appointments. In relation to a new shower that Ms A needed to improve her personal hygiene, the Advocate reported that it had been installed, though Ms A said that the work had not been finished. The minutes also noted that Ms A had been visiting her mother regularly, and:

'[The Advocate] confirmed she has contacted [Ms C] regularly and this contact has been positive.'