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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint by Mrs X against Gwynedd Council

A report by the
Public Services Ombudsman for Wales
Case: 201700388

The Complaint

1. Mrs X complained about Gwynedd Council's ("the Council") decision to reduce her son, Mr A's, social services support provision. Mrs X said that the Council:

- Failed to provide adequate support for Mr A and disregarded his needs as a person with Autistic Spectrum Disorder ("ASD").[1] This included ignoring the care and treatment plan[2] created in May 2016
- Failed to monitor its service contract and review Mr A's services, resulting in an unlawful and unjustified cut in his support hours
- Failed to adequately communicate with her and maintain appropriate records
- Failed to fully investigate her complaints in accordance with the Social Services Complaints Procedure (Wales) Regulations 2014 ("the 2014 Regulations").[3]

Investigation

2. I obtained comments and copies of relevant documents from the Council and considered those in conjunction with the evidence provided by Mrs X. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

3. I have taken advice from one of the Ombudsman's professional advisers. The Adviser, Chris Pearson, is a registered social worker. When making my decision, I have taken into account the Adviser's comments, which I have accepted in full.

4. Both Mrs X and the Council were given the opportunity to see and comment on a draft of this report before the final version was issued.

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[1] A lifelong developmental disability which affects a person's social interaction, communication, interests and behaviour. The characteristics of ASD vary, with some people finding it hard to understand other people's emotions and some with restricted and repetitive patterns of behaviour.
[2] This identifies eligible needs.
[3] This states that the complaint should be acknowledged within two working days from receipt. Local resolution of the complaint should be offered and a meeting should take place within 10 working days from the acknowledgement; this deadline may be extended with the complainant's consent. The response should be provided within five working days of the agreed resolution. Where a complainant requests a formal investigation, an independent investigator should be appointed to consider the complaint. The Council should provide a response within 25 working days.

5. I am issuing this report under the authority delegated to me by the Ombudsman under paragraph 13(1) of Schedule 1 to the Public Services Ombudsman (Wales) Act 2005.

Relevant background information and events

6. Mr A had a diagnosis of ASD, mental health problems and Gender Identity Disorder (when a person feels distress or discomfort caused by a mismatch between their biological sex and the gender the person identifies themselves as being). Following a period of crisis in 2011, Mr A, then aged approximately 27 years old, moved into supported living accommodation for people with severe and enduring mental illness ("the Residential Home"). Mr A received support from the Community Mental Health Team ("CMHT"), a care co-ordinator (the main point of contact responsible for co-ordinating a person's care and treatment) and 24 hours of one to one support, to aid his mental health recovery. Whilst Mr A had the mental capacity to make decisions about his care and treatment, Mrs X said that his ASD caused him anxiety when presented with new information and asked to make a decision. Mr A required time and support to comprehend information and the impact it would have on him. Mr A would seek reassurance from, or be influenced by, those present when responding, which meant that he would readily agree to an action without understanding what had been discussed or its impact. Mrs X said that Mr A needed to feel comfortable with a person before he would share his deeper thoughts and feelings.

7. Whilst Mr A's **2014** care and treatment plan recommended that he receive 24 hours one to one support per week, he did not receive his allocated hours. Instead, the Residential Home re-allocated a significant portion of Mr A's support hours to bridge gaps in its staffing needs. There is no evidence of the Council authorising the redistribution of Mr A's hours. There is evidence, however, that Mr A's activities had significantly dwindled from varied, daily activities to going to a public house on two evenings a week, on his own and attending a weight loss club on one evening a week, on his own; both activities being part of Mr A's routine for some time. Despite his requests, Mr A was no longer undertaking voluntary work or attending College as he had done previously.

8. On 15 October **2015**, the Council's Reviewing Officer ("the Reviewing Officer") met with Mr A to undertake a "Social Worker's Specialist Assessment" ("the October 2015 assessment").[4] The Residential Home Manager and Mr A's care co-ordinator ("the First Care Co-ordinator") also attended the assessment. Mr A was not asked if he wanted his parents or an advocate with him during the assessment. There is no evidence to demonstrate what regard the Reviewing Officer had for Mr A's ASD, in accordance with the Welsh Government's ASD Strategic Action Plan 2008 ("ASD SAP")[5] when communicating information to him or asking him to make a decision.

9. The October 2015 assessment found that Mr A's mental health had stabilised significantly since he first moved into the Residential Home and it was believed that Mr A could be more independent with encouragement. It also found that Mr A did not fully utilise the 24 hours support he had been allocated per week. The report states that there was a discussion about gradually cutting Mr A's hours from 24 to 8 hours per week to give Mr A an opportunity to adapt. The assessment also stated that cutting Mr A's support hours from 24 to 8 would result in a significant saving. The assessment, which was dated 24 November 2015 and not signed by Mr A, does not state whether Mr A fully understood and agreed with either the content or the reduced package of care.

10. At the same time, a review was also undertaken of Mr A's care and treatment plan. This care and treatment plan reflected the findings of the October 2015 assessment, stating that a reduction in hours would promote Mr A's independence and support building self-reliance and recovery. It was agreed that a review of the reduced hours would be undertaken in three months' time.

11. On 6 November, Mrs X submitted a complaint on Mr A's behalf. Mrs X said that the Council had undertaken a review of Mr A's needs without giving him an opportunity to have support and representation available. Mrs X also said that Mr A had been misled by the Reviewing Officer about the consequences of the changes.

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[4] An assessment undertaken by someone with specialist skills, knowledge or expertise.
[5] This states that the assessment process should take account of the inherent lifelong difficulties of inflexibility in thinking and the consequential pervasive impact upon its decision.

12. The Council responded to the complaint on 19 November stating that, both Mr A and the Residential Home staff had been given plenty of notice of the review and it had been open to them to invite Mr and Mrs X or Mr A's advocate to attend. Mrs X was unhappy with the response and forwarded further concerns to the Council on 23 November. Mrs X also requested a copy of the documentation considered by the Reviewing Officer during the assessment, including Mr A's activity diary and his care and treatment plan.

13. On 13 December, having received a copy of Mr A's care and treatment plan, Mrs X submitted a complaint to the Council stating that there was no evidence to justify the reduction in Mr A's support.

14. On 11 January **2016**, Mr and Mrs X met with the Council to discuss the changes to Mr A's support. During the meeting Mr and Mrs X were told that Mr A had not been making full use of the 24 hours of support allocated and that his excess hours were being used to provide services to other residents. The Council reiterated the outcome of the October 2015 assessment and associated care and treatment plan. The Council also said that the review had been driven on producing the maximum benefit for Mr A, not making savings. That said, the money saved would be used to purchase two permanent members of staff at the Residential Home to aid residents with their activities of daily living. It is noted that not all of Mr and Mrs X concerns were addressed at the meeting.

15. In May, having undertaken research on ASD, the First Care Co-ordinator completed a care and treatment plan for Mr A which included a recommendation that his support hours be increased from 8 to 30 hours per week. This assessment included input from Mr A, his advocate, Mr and Mrs X and the Residential Home Manager.

16. On 20 May, the Care Co-Ordinator undertook a Specialist assessment of Mr A's needs ("the May 2016 assessment"). This assessment process was very lengthy, and again included input from Mr A, his advocate, Mr and Mrs X and the Residential Home Manager. The First Care Co-ordinator concluded that a lack of understanding by staff at the Residential Home and the Reviewing Officer meant that Mr A's needs had not been fully recognised. Furthermore, staff absence at the Residential

Home had prevented Mr A from fully utilising his previous allocation of support hours. It was noted that the additional hours would allow Mr A to engage in the educational training and voluntary work from which he was precluded due to the lack of support and the anxiety and distress caused by his condition.

17. The request for extra hours was not approved by the Council's Funding Panel ("the Panel"). The reason for this was that the number of hours requested was more than Mr A had previously been receiving and there was no evidence of any significant changes since the previous review to justify the increased level of support. The Panel requested another specialist assessment be completed by a Social Worker to evidence why the increase in the hours should be provided.

18. On 24 June, the First Care Co-ordinator left the post.

19. On 3 July, Mrs X wrote to the Council expressing concern that Mr A's care and treatment plan had still not been implemented, leaving him without adequate support and a care co-ordinator.

20. Mr A was allocated a new care co-ordinator ("the Second Care Co-ordinator") at the end of July 2016. The Second Care Co-ordinator was not an ASD specialist, but had experience supporting another service user with ASD. On 9 August, Mrs X was informed that the Second Care Co-ordinator intended to undertake an in-depth assessment of Mr A, despite not having met him previously. Mrs X was told that a decision would be jointly made with the Integrated Team Manager and the Complex Team Manager on the type of support and number of hours that Mr A needed. Mrs X said that Mr A was given two days' notice of the assessment and that, again, the review was arranged without checking that there would be someone available to support Mr A during the process.

21. On 15 September, Mrs X wrote to the Council, escalating her complaint. Mrs X also said that, by refusing to implement Mr A's care and treatment plan, the Council had failed to meet its statutory duty.

22. On 19 September 2016, the Council appointed an Independent Investigator to consider Mrs X's complaint. The Independent Investigator met with Mr and Mrs X on 27 September to discuss Mrs X's concerns.

23. During the Independent Investigator meeting with the Council's officers on 4 October, it was acknowledged that, whilst Mr A's continued care and support at the Residential Home was dependent on the funding decision, there had been a delay in undertaking the specialist assessment requested by the Panel because there was no one suitable available to undertake it. As a result, Mr A had to continue without support until an appropriate officer was available. It is noted that due to time constraints, the Independent investigator was unable to complete the interview and a written response was provided for the outstanding questions.

24. The Independent Investigation report was submitted to the Council on 5 November 2016. Most of the complaints were not upheld. In response to the two recommendations that were made, the Council undertook to hold discussions with the Contract and Commissioning Unit about the accurate recording of support hours and to improve the information about ASD on its website.

25. On 19 December, the Second Care Co-ordinator completed a care and treatment plan for Mr A. It is noted that there was no reference to Mr A's ASD in this plan.

26. Another care and treatment plan was completed for Mr A on 10 January **2017**. This plan makes more reference to Mr A's needs and the effect of ASD on his daily life.

27. On 20 April, Mrs X submitted a complaint to this office. At that stage, Mr A did not have an implemented care and treatment plan.

Mrs X's evidence

28. Mrs X said that the Council's failure to have suitably trained ASD officers, an ASD plan and appropriate residential facilities for people with ASD and other needs meant that Mr A's ASD needs were largely ignored. Mrs X said that this lack of knowledge and understanding meant that the

officers working with Mr A attributed him with significantly greater understanding, comprehension and communication skills than he had. In Mrs X's opinion, the Council should consider placements outside the Council's area to ensure that Mr A's needs are being met and he is given a chance to develop and lead a fulfilled and happy life.

29. Mrs X said the Reviewing Officer's comment that Mr A had "excess hours" was disingenuous and did not reflect the fact that most of Mr A's support hours were being used by the Residential Home to bridge its staffing issues; a point which the Reviewing Officer appeared to be fully aware. Mrs X said that, had the Reviewing Officer considered all the information available, including Mr A's daily activity sheets, it would have been obvious that Mr A had not been receiving adequate support for some time, that his activities had significantly decreased and were not being renewed and that he was being left in bed for most of the day with no encouragement to get up and engage. Mrs X said that Mr A was in a steady decline, which Mrs X feared would result in a crisis situation. Mrs X said that, to add to the distress, Mr A had been told that he may lose his remaining eight hours support if he could not prove he needed them. Mrs X said that this demonstrated how, despite being aware of Mr A's ASD, the Council failed to understand its effect on Mr A's capabilities. Additionally, having asked Mr A to identify and request new activities to justify his support hours, he was not given any help with this task. Furthermore, his current provider has indicated that it is unable to support Mr A's current eight-hour allocation.

30. Mrs X said finding out that Mr A's support package had been drastically cut had caused significant upset and distress. Mrs X said that the Council's decision not to invite her or Mr A's Advocate to the October 2015 assessment, because there had been no significant changes to Mr A's care needs, was a further example of the failure to understand the effects of ASD on Mr A. Mrs X said that giving Mr A a pre-typed care and treatment plan to sign on the day of the interview was wholly inappropriate, suggested pre-determination and failed to take into account the time Mr A needed to understand the content of the plan and the impact on the services he received.

31. Mrs X said that, rather than implementing the May 2016 care and treatment plan and providing Mr A with the support he required, he was forced to continue with no support, no continuity of care and was continually re-assessed by the Council; a process he found very stressful.

32. Mrs X said that, despite the definition of a vulnerable adult being "a person who is 18 years or over, and who may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to protect himself against significant harm or serious exploitation",[6] and the definition of an adult at risk being "an adult who is experiencing or is at risk of abuse or neglect; has needs for care and support and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it",[7] the Council refused to acknowledge that Mr A was a vulnerable adult or at risk unless something happened to him. Mrs X said that in her view the Council's failure to provide Mr A with appropriate support was tantamount to neglect.

33. Mrs X said the Council's view was that, "since Mr A did not complain, everything must be fine," was wrong. Unlike some people who are serial complainers, Mr A is a serial acquiescent, which places him at risk of being hurt or exploited.

34. Mrs X said that this matter could have been resolved by the Council implementing Mr A's care and treatment plan in May 2016. Instead, the Council's continued failings have caused a breakdown in the relationship between Mrs X and the Council, as well as stress and additional health problems for Mrs X and a significantly detrimental effect on Mr A's recovery and lifestyle.

Mrs X's comments on the draft report

35. Mrs X said that very little has happened to help Mr A since the complaint was made to the Ombudsman. However, Mr A had been allocated an additional four hours support a week to attend a college course.

[6] Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse; version 2; January 2013
[7] The Social Services and Wellbeing (Wales) Act 2014 ("SSWA 2014")

Unfortunately, that support will stop at the end of the academic year rather than continue and be used to assist Mr A with choosing and applying for a new course to start in September.

36. Mr A's remaining eight hours are all on a Tuesday and, in Mrs X's view, for staffing reasons, include an early start, which is not suitable for Mr A and not the best use of his support hours. The rest of the week, Mr A has no individual support and no motivation. Mrs X said that she has requested that Mr A's hours are increased and spread over the week so that his ASD needs can be met more effectively. Mrs X said that this suggestion has been dismissed as impractical.

37. Mrs X said that Mr A has not had any contact with his Care Co-ordinator for many months. However, Mr A is now seeing an Occupational Therapist on a "semi-regular basis" which he is finding helpful.

38. Mrs X said that Mr A's unmet needs form had been submitted however, they have not seen the content or been given the opportunity to comment on the document. Mrs X also said that nobody has explained the process following submission or how it will help Mr A's circumstances.

39. Mrs X said that there continues to be little understanding of how Mr A's ASD affects his everyday thinking.

The Council's evidence

40. The Council said that the Residential Home staff, with additional support from Mr A's care co-ordinators encouraged Mr A to be self-motivated and as independent as possible. Mr A was provided with support to undertake tasks associated with daily living as well as his educational and wellbeing needs with a view to aiding his recovery and achieving his aspiration of social inclusion and independent living.

41. The Council said that the Reviewing Officer discussed her intention to assess Mr A with the Residential Home Manager several days before the visit. The Reviewing Officer did not consider it to be essential that Mr A's family or an advocate was present because Mr A was an adult with capacity to understand the proposed revisions to his care plan. The Council said that

Mr A had been given notice of the meeting and it would have been up to him to invite his parents or advocate to attend if he had wanted them there. The Council did recognise that, since Mr and Mrs X had been invited to previous meetings, an invitation could have been extended to this meeting.

42. The Council said that the decision to reduce Mr A's support was not done on a purely financial basis. The Council recognised its obligations under the Mental Health (Wales) Measure 2010 ("MHM 2010") and SSWA 2014 while keeping in mind the limited financial resources available. The Council said that, whilst this could be a challenge, the emphasis was on meeting Mr A's needs in the most effective way when deciding on the content of a care plan. The Council said that, in this case, it was clear from the Residential Home records that Mr A was not using all 24 hours support that had been allocated to him. Most of the time Mr A used was for motivating him to get out of bed and dressed.

Professional Advice

43. The Adviser said that neither the October 2015 nor the May 2016 assessments considered all the areas identified in the MHM 2010; Code of Practice. Furthermore, there was no evidence that the ASD SAP was considered during these assessments.

44. The Adviser said that the October 2015 assessment was not a re-assessment of need; rather it was a review of Mr A's placement and care package. The focus of the review was to determine how much benefit Mr A had from the 24 hours of one to one support he received each week. The Adviser said that, to determine the benefits that Mr A enjoyed from the support, a holistic assessment needed to be undertaken which specifically related to Mr A's care and treatment plan. In this case, there is no indication how the assessment related to Mr A's care and treatment plan or the impact of his ASD. Furthermore, the Reviewing Officer did not involve Mr A in a holistic context or involve the key people in his life who know him best.

45. The Adviser said that, in his view, the October 2015 assessment did not follow due process. Whilst Mr A had capacity to make decisions about his life, he became anxious and sought reassurances from staff when making those decisions. There is no indication that Mr A's anxiety or

persuasive nature was considered during the October 2015 assessment process, or how the information about the reduced package of care and its consequences had been communicated to Mr A. The Adviser said that, in his view, Mr A's needs and the impact of his ASD had not been considered. It would have been in Mr A's best interests to have asked if he wanted his parents or advocate with him during the assessment and documented his thoughts during the process.

46. The Adviser said that the May 2016 assessment not only included input from Mr A and his parents, it placed greater emphasis on Mr A's ASD and reinforced Mr A's concerns and struggles with processing information at the same pace as other people. The Adviser said that the proposal to increase Mr A's support hours to 30 per week would have resolved a number of issues for him. The Adviser said that the outcome of the May 2016 assessment highlighted the failings of the October 2015 assessment and the failure to consider Mr A's co-existing mental health problems and ASD.

47. The MHM 2010 empowered the care co-ordinators to formulate decisions and make commitments on behalf of the Council. The Adviser said, in view of that, there was no viable reason why the May 2016 care and treatment plan was not actioned.

48. The Adviser said that neither Mr A nor Mrs X were kept adequately informed about Mr A's care and support provision. Furthermore, by placing the onus on Mr A to inform his parents or Advocate about upcoming assessments, meetings or their outcomes, the Council ignored the impact of ASD on Mr A, particularly his inflexibility in thinking and the persuasive impact on decision making.

49. The Adviser said that Mr A's care and treatment plan remains in abeyance with no intended date for implementation. This is professionally unacceptable and goes against statutory guidance,[8] which promotes equitable access to, and provision of, mental health services.

[8] MHM 2010; Code of Practice, Part 2
SSWA 2014

50. The Adviser said that the fact the care and treatment plan is not in place should have, at least, caused the Council to identify an unmet need. The Adviser said that, in his view, the Council should have accepted the assessed eligible needs and care identified in May 2016 and subsequently written in the care and treatment plan.

51. The Adviser said that, once a Council has agreed eligible needs, as in the May 2016 care and treatment plan, there is case law that says it has a duty to provide the arrangements. [9] Therefore, the decision not to accept Mr A's assessed needs suggests that the cut in resources was the sole reason for the Panel's decision.

Analysis and conclusions

52. Mrs X complained that the Council failed to provide adequate support for Mr A, disregarded his needs as a person with ASD and ignored the May 2016 care and treatment plan. Having reviewed the information available to me, I **uphold** this element of the complaint.

53. It is my view that, whilst Mr A's mental health problems had resulted in his placement at the Residential Home and the allocation of one to one support hours, his ASD and mental health problems are intrinsically linked, so Mr A's ASD must be a constant consideration.

54. It is clear from the evidence that, contrary to the ASD SAP, the Council's officers do not have sufficient knowledge and understanding of the effects of ASD. The Council's available ASD information, including its strategic plan for ASD services, particularly services for those with high functioning ASD,[10] are limited. This has had a significant impact on Mr A and the service he has received from the Council as his mental health problems improved.

55. By October 2015, Mr A's activities had reduced significantly to only those he was able to undertake without support. It is noted that these activities were only possible because Mr A had previously been given

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[9] R v Islington LBC ex p McMillan (1997 -8) 1, CCLR 7, QBO

[10] People with a diagnosis of ASD and an IQ of 70 or greater (the average IQ in the UK is 100)

support to integrate them into his routine so that he would be comfortable enough to undertake them alone. Mr A was also being left in bed for lengthy periods of the day rather than motivated to get up and engage. A significant portion of Mr A's support hours were not being used for the purpose for which they had been commissioned.

56. The Reviewing Officer had little understanding of ASD and the effect of this on Mr A's behaviour and mental health problems. As a result, when the Reviewing Officer undertook the assessment of Mr A's needs, there was a failure to take a holistic approach. In my view, the focus was on Mr A's ongoing recovery from his mental health problems and financial savings. Furthermore, it appears that, despite being aware that Mr A's support hours were not being utilised by him due to staffing reasons, this was not considered when making the decision to reduce his support. In my view, this was not reasonable. Rather than reducing Mr A's hours, the Reviewing Officer should have assessed whether the Residential Home was able to meet his needs. Whilst Mr A was continuing to function without the full complement of hours, he was not leading a full, varied and meaningful life, with many of the activities he enjoyed not being replaced and no opportunities to continue with his education or voluntary work (areas which appear to be very important to Mr A).

57. It is evident that the Reviewing Officer and, subsequently, the Council, in its complaint response, placed significant weight on Mr A having the capacity to make decisions about his care and treatment without taking any account of what that meant for Mr A as a person with ASD. Responsibility was placed on Mr A to seek support and advocacy; something the inflexibility in Mr A's thinking, resulting from his ASD, would have prevented him from doing and should have been considered when formulating the meeting. It is my view that, given the lack of experience with ASD, it would have been good practice for the Reviewing Officer to have discussed the effects of ASD on Mr A with Mr and Mrs X and his keyworkers before undertaking the assessment.

58. There is no evidence in the records that any reasonable adjustments had been made to aid Mr A in understanding the purpose of the assessment, its outcome and its consequences. It appears that, since Mr A

agreed with what had been said, a symptom of his ASD, the Reviewing Officer accepted that he understood and agreed with the decision; this was not the case.

59. There is a stark contrast between the outcomes of the October 2015 and May 2016 assessments. The latter assessment was undertaken with input from Mr A, his advocate and Mr and Mrs X by the First Care Co-ordinator after she had undertaken research on ASD and taken time to understand the effect of ASD on Mr A's mental health and behaviour.

60. The records show that, up to April 2017, Mr A did not have an active care and treatment plan in place and received no support. Mrs X has raised very real concerns about Mr A deteriorating and ending up in crisis. I am concerned that the Council has failed to meet it statutory obligations to Mr A by not accepting his assessed eligible needs. I am also concerned that the Council has based the final decision for services with the Panel who, even if it is not the Council's intention, appears to be financially motivated when making a decision.

61. It is my view that the failings identified have caused Mr A an injustice. He has been without his assessed level of support for a lengthy period of time which has placed his recovery at significant risk. Additionally, the Council's failure to ensure that its officers receive appropriate ASD training and have an ASD strategy in place places not only Mr A, but other service users in its area at risk of having services cut or stopped because the reviewing officers do not understand the effects of ASD or there is nothing suitable available.

62. Mrs X complained that the Council's failure to monitor its service contract and its review of Mr A's services resulted in an unlawful and unjustified cut in support hours. Having considered the information available to me, I **uphold** this element of the complaint.

63. It is my view that the October 2015 assessment was a placement review rather than an assessment of need. The focus of the October 2015 assessment was to determine how much benefit Mr A enjoyed from his support hours rather than what support he needed to lead a fulfilled life.

This appears to be contrary to the spirit of the SSWA 2014 and MHM 2010 which requires a holistic approach taking into account the care and treatment plan.

64. The Reviewing Officer's view that Mr A could take the initiative and request any necessary support he required for the October 2015 assessment, demonstrated a lack of understanding of the effects of Mr A's ASD on his behaviour and capabilities. The Reviewing Officer also placed significant weight on Mr A's capacity to make decisions about his care and treatment without finding out how he should be supported to make those decisions. This resulted in Mr A agreeing to detrimental changes in his support without understanding the consequences.

65. The Reviewing Officer's view that, since Mr A was not using all of his support hours, they were excessive, and his package could therefore be reduced, is concerning, since the Reviewing Officer was not only aware that the Residential Home had reallocated most of Mr A's support hours to bridge the staffing gap, but also there was no evidence that Mr A's support needs had changed enough to justify such a substantial reduction. Furthermore, there is no evidence that the Reviewing Officer fully explored the effect the reduced activities had on Mr A's recovery.

66. Contrary to its statutory duty, the Council refused to implement the May 2016 care and treatment plan without a further assessment; despite staff shortages significantly delaying the process. As a result, Mr A was denied any support for a lengthy period of time.

67. The Council said that the focus of the October 2015 assessment was not financial, yet it reduced Mr A's support despite there being no significant changes to Mr A's needs. Then, following the May 2016 care and treatment plan recommendation to increase Mr A's hours to 30 per week the Panel declined on the basis that Mr A's needs had not changed. Whilst it may not be the intention, this suggests financial motivation.

68. During the October 2015 assessment process, the Reviewing Officer became aware that the Residential Home had reallocated a significant portion of Mr A's support hours to bridge its staffing gap. Despite there being no evidence that this had been agreed with the Council as the

commissioning body, this was not explored with either Mr A or the Residential Home. It appears that this arrangement had been going on for some time and it is of some concern that, as a result of its failure to appropriately monitor the services it commissioned with the Residential Home, the Council did not appear to have been aware of this, or that Mr A had been caused a detriment or that other residents who received that service instead may have been placed at risk.

69. In my view, these failings not only caused Mr A a significant injustice but also impacted upon Article 8 of his Human Rights.[11] However, I have decided that the finding I have made of maladministration is so clear and so serious that to consider the human rights issues further would add little value to my analysis or to the outcome. I have therefore decided to say no more about that.

70. The Reviewing Officer's failure to take Mr A's ASD into account meant that he underwent a significant review without understanding the purpose, the content or the consequences of the decisions made. Mr A was continually denied support with no regard given to meeting his ongoing needs during the interim period or the significant risk of deterioration and another crisis. Furthermore, the Council's failure to monitor the commissioned support hours meant that Mr A was denied important support while the Residential Home bridged its staffing gap, this was not appropriate and not only questions the Residential Home's capability to meet all the residents' needs but also highlights the gaps in the Council's process for recognising and addressing these shortfalls so that all service users receive appropriate commissioned care and treatment.

71. Mrs X complained that the Council failed to adequately communicate with her and maintain appropriate records. Having reviewed the evidence available to me, I **uphold** this element of the complaint.

72. It is evident that throughout this process, Mrs X has been excluded from important review meetings and assessments relating to Mr A's needs. Despite Mrs X's comments and concerns, the impact of Mr A's ASD on

[11] Article 8 Human Rights Act 1998 – right to respect for family and private life, home and correspondence; which includes being supported to live independently

decision making and the significant difference in the outcome of the October 2015 assessment when compared to the May 2016 assessment, which included input from Mr A, Mr and Mrs X and the advocate, the Council did not take these matters into consideration before arranging the August 2016 assessment. Additionally, there is no evidence of any reasonable adjustments made by the Council when explaining the assessments or their subsequent outcomes to Mr A. This was of concern given Mr A's difficulty processing information and his willingness to agree to what he was being told, regardless of his understanding. Furthermore, whilst Mr A was an adult with capacity to make decisions about his care and treatment, given the previous input and support of his family and advocate and the effects of his ASD, I was surprised that neither Mrs X nor the advocate were told about these meetings or the outcomes.

73. With respect to the record keeping, I note that the October 2015 assessment document was unsigned. This is not appropriate given that this document was used by the Council as a basis for its decision to reduce Mr A's support.

74. It is my view that these failings have caused Mr A an injustice. The Council actioned the content of an unsigned assessment that had been formulated without any input from Mrs A's family or advocate which resulted in a detriment to Mr A, yet failed to action signed assessments where all parties had been involved in the formulation and where consideration was given to Mr A's ASD, leaving Mr A with no support.

75. Mrs X complained that the Council failed to fully investigate the complaints that she made under the 2014 Regulations. Having reviewed the evidence available to me, I **uphold** this element of the complaint.

76. It appears that, when responding to Mrs X's complaint, the Council failed to meet the timescales within the 2014 Regulations (see paragraph 1), particularly when responding to the complaints dated 13 December 2015 and 15 September 2016.

77. The evidence also shows that, having agreed to meet with Mr and Mrs X on 11 January 2016 to discuss their concerns, the Council did

not allocate sufficient time and there was a failure to use that opportunity to fully address all the concerns during the meeting. I note that this happened again with the Independent Investigator on 4 October.

78. Finally, I am concerned that when responding to Mrs X's complaint, the Council failed to address her most fundamental concerns about the decision to disregard Mr A's ASD and the effects of those decisions. Furthermore, had the Council undertaken its statutory duty and implemented the recommendations in Mr A's care and treatment plan this complaint would not have been made.

79. It is my view that these failings caused Mrs X an injustice. Specifically, the breakdown in Mrs X's trust of the Council and its capability in looking after her son as well as causing her to raise continued and more protracted complaints about Mr A's care.

Recommendations

80. I **recommend** that, within one month of the final report, the Council:

(a) Apologises to Mr A for the service failings identified in this report

(b) Apologises to Mrs X for the communication and complaint handling failings identified in this report

(c) Pays Mr A £1500 in recognition of the failings identified in this report

(d) Pays Mrs X £250 in recognition of the time and trouble that she experienced in bring her complaint to this office

(e) Ensures that Mr A's care and treatment plan is put in place and that he is given appropriate time and support from Mr and Mrs X and/or his advocate before any decisions are made regarding his support.

81. I **recommend** that, within six months of the final report, the Council:

(f) Reviews its process on monitoring commissioned services for adults

(g) Undertakes a review of its ASD procedures, specifically those for adults and children with high functioning ASD, and ensure that the requirements of the SSWA 2014, MHM 2010 and ASD SAP have been met.

(h) Undertakes an audit of its ASD trained officers, identifies any shortfall and arranges appropriate training within the following 12 months.

82. I am pleased to note that in commenting on the draft of this report **the Council** has agreed to implement these recommendations.

Beverley Allen 4 July 2018
Investigation Officer

ENDNOTE

This document constitutes a report under s.21 of the Public Services Ombudsman (Wales) Act 2005 and is issued under the delegated authority of the Ombudsman.

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