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Tom's Case

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Background Information

- Tom was diagnosed with severe learning difficulties, hyperkinesis and epilepsy.
- After more than 30 years in hospital Tom was discharged to his own home with a 24 hour care and support package on 14 November 2003.

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Background Information (2)

- On 6 December 2008 Tom suffered a serious injury while being cared for by a care worker.
- On 9 December the Care Commission were notified of the incident.
- Police, Local Authority and Care Commission all ‘investigating’.

Background Information (3)

- On 19 December 2008 Tom's sister made a complaint to the Care Commission about the care that Tom had received.

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Summary of complaint activity

- Complaint made on 19 December 2008.
- 23 December 2008 complaint status changed to ‘withdrawn’ by ‘EF’ and subsequently this was challenged.
- 27 February 2009 complaint status reinstated by ‘GH’.
- During the period 27 February 2009 to 31 January 2013 the investigation was extended 18 times.

Attempts at agreeing the allegations for investigation

- 5 formal attempts with each time Tom's sister seeking amendment or introducing new allegations.
- 'IJ' on 16 March 2009.
- 'GH' on 18 August 2011.
- 'EF' on 14 February 2012.
- 'KL' on 17 September 2012.
- 'MN' on 24 January 2013.

Summary of complaint case handling

- 27 February 2009 ‘GH’ reinstated complaint.
- 18 April 2011 ‘IJ’ handed over responsibility to ‘GH’.
- 1 November 2011 ‘GH’ handed over to ‘EF’.
- 7 January 2013 ‘OP’ and ‘MN’ take over responsibility.
- 25 February 2013 resolution letter sent by ‘MN’.

‘The Malestrom’

- Tom’s sister very frustrated with both the local authority and the Care Inspectorate.
- Tom’s sister believes that Tom has been forgotten and that there is an institutionalised ‘cover up’.
- Tom’s sister campaigning in the media and bombarding the local authority and Care Inspectorate with letters and emails.

‘The Malestrom (2) ’

- Care Inspectorate staff feeling under threat.
- Strained relationships with key partner agencies.
- ‘Political interest’

Risks

- Public confidence in the Care Inspectorate's ability to effectively and efficiently conduct complaint investigations.
- Public confidence in care provision commissioning and delivery arrangements.
- Public confidence in the local authority.

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‘Some of the Learning’

- Introduction of a decision making model that assists colleagues take decisions with confidence and record their rationale.
- Introduction of ‘single point of contact’.
- The need to not become ‘person blind’, defensive and process focused.
- The need to truly put the ‘person’ at the centre of the investigation.

‘Some of the Learning (2)’

- The need to ensure that there is appropriate leadership and ‘grip’ on the situation at the outset.
- The need to identify ‘flags’, ‘pointers’, and ‘indicators’ that highlight a situation is out of the ordinary.
- The need to minimise incidents escalating ‘out of control’.

‘Critical Incident’

- “Any incident where the effectiveness of the Care Inspectorate response is likely to have a significant impact upon the confidence of the service user, the service user’s family and/or the community.”

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‘Criticality Factors’

Does your incident have any of the following features?			
Death	Media interest	Failure to follow standard operating procedures/policy	Wider community issues
Serious injury	Significant harm	Local interest	Regional interest
National interest	Vulnerable service user	Prominent service user	Repeat service user
Repeat location	Repeat offender	Prominent offender	Large numbers of service users
Care Inspectorate error	Minority community issues	Prominent location	Staff misconduct
Failure within the care system	Offender from within the care system	ICT systems failure	Political interest

Likely significant impact on the:		
The service user	Their family	The community

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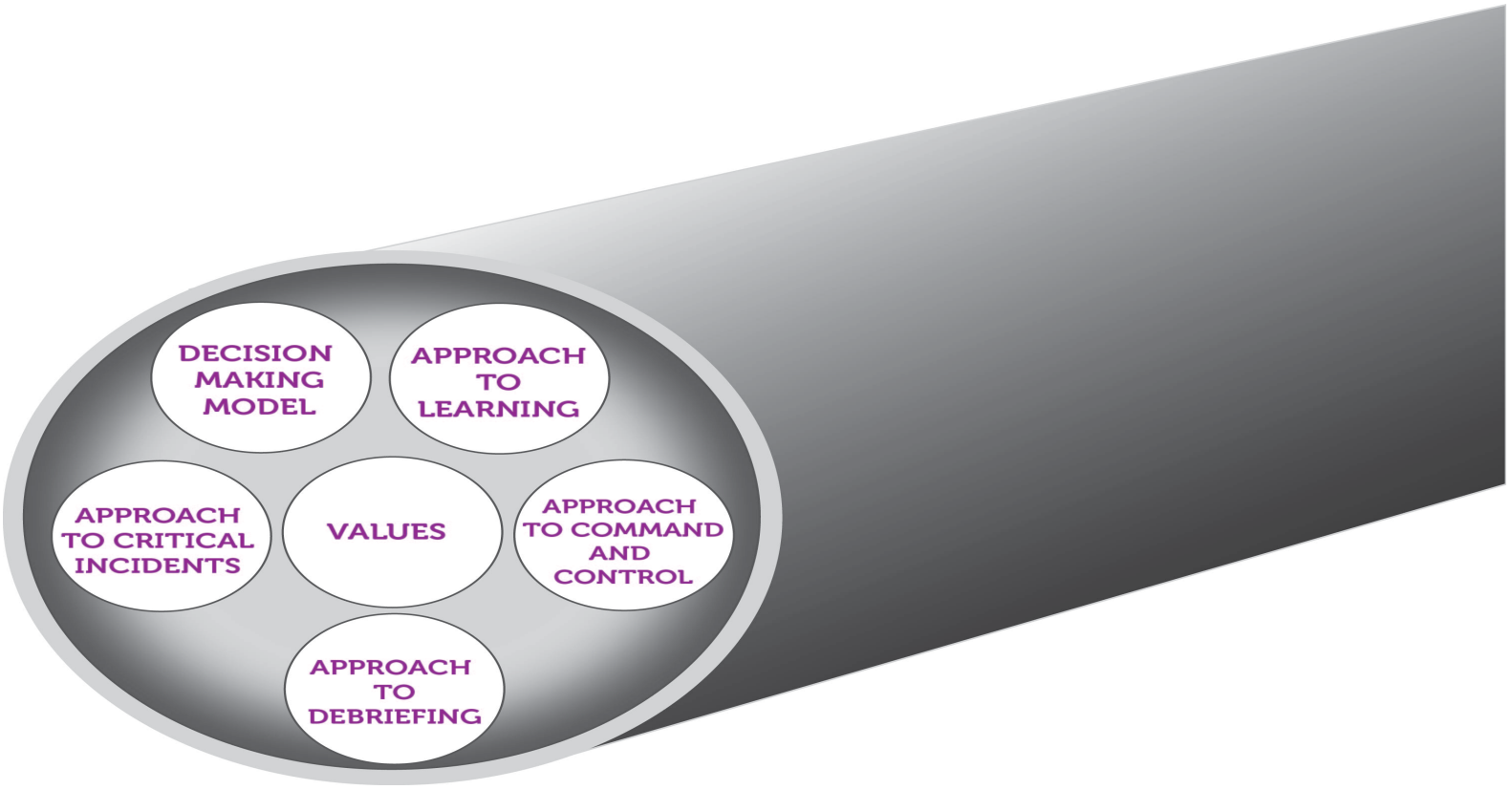
Useful questions to ask

- What am I dealing with?
- What might this develop into?
- What impact might this incident have?
- Whom should I tell if I think this may escalate into a critical incident?

Linked ongoing work



The ‘Oslo questions’ (1)

- “What information did I use?” – In examination of this particular case it was necessary to examine a vast quantity of records held electronically and on paper. The volume of information was potentially overwhelming.

‘The Oslo questions’ (2)

- “What information could have been used?” – Emails, letters, notes, minutes of meetings, witness statements etc were examined. Face to face interviews could have been carried out but this was decided against.

‘The Oslo questions’ (3)

- “What could have prevented this situation?” – Can’t give a view on the original incident but the organisational response would have been improved by early identification of the ‘criticality factors’.

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Any questions?