23 March 2018

Complaint references:
LGO reference: 17 003 579
PHSO reference: C2018698

Complaint against:
City of York Council
Tuxford Medical Centre
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

Parliamentary and Health Service Ombudsman

The Ombudsmen's decision

Summary: The Ombudsmen find no fault in the way a care home and GP practice responded to a resident's declining health, or in the way the home tried to manage the resident's personal care needs. However, the Ombudsmen find fault in way the care home managed the resident's pressure area needs. This caused an injustice. The Ombudsmen recommend an apology and an action plan to address this.

The complaint

1. Mr A complains about the care, support and treatment his late mother, Mrs R, received from September 2015 until January 2016. He complains about:

- Tuxford Manor Care Home (the Care Home), which City of York Council (York Council) arranged and funded while Mrs R stayed there
- Tuxford Medical Centre (the Practice)
- Nottinghamshire County Council (Notts Council), which investigated Mr A's concerns.

2. Mr A complains:

- **The Care Home failed to investigate Mrs R's complaint of being attacked in her bedroom.** Mr A said Mrs R complained about this shortly after she moved in to the Care Home. Mr A said, because the Care Home failed to investigate, Mrs R lost trust in the professionals involved in her care. He said this, in turn, meant she stopped sharing things with them, such as the pain she was in.
- **The Care Home and Practice failed to address Mrs R's deteriorating health during December 2015 and January 2016.** Mr A said there were clear signs that Mrs R's health was deteriorating due to treatable medical problems. Mr A complains his mother's death was painful and undignified and could have been avoided had appropriate care been provided in a timely manner. In particular, Mr A complains the Care Home and Practice failed to take proper account of Mrs R's:
    - Inability to eat and associated weight loss
    - Inability to drink and severe dehydration

- Increasing abdominal pain
- Inability to pass stool
- Increasingly restricted movement.

- **The Care Home failed to provide proper personal care for Mrs R.** Mr A said Mrs R needed help with elements of her daily personal hygiene needs. He complains the Care Home failed to provide this help. Mr A said, as a result, his mother was unable to use the toilet when she wanted to and was left in urine soaked underwear. Mr A complains this, in turn, meant Mrs R developed avoidable urine acid burning between her legs.
- **The Practice failed to recognise signs the Care Home was not providing proper personal care for Mrs R.** Mr A said the Practice should have noticed evidence of poor care during their examinations of Mrs R.
- **The Care Home failed to provide proper pressure area care.** Mr A said Mrs R developed an avoidable pressure sore on her heel because of this.
- **Notts Council failed to investigate his concerns adequately or objectively.** Mr A complains Notts Council accepted the professionals' versions of events without any scrutiny or analysis.

The Ombudsmen's role and powers

3. The Ombudsmen have the power to jointly consider complaints about health and social care. Since April 2015, these complaints have been considered by a single team acting on behalf of both Ombudsmen ***(Local Government Act 1974, section 33ZA, as amended, and Health Service Commissioners Act 1993, section 18ZA).***

4. The Ombudsmen will not generally investigate a complaint unless they are satisfied the matter has been brought to the relevant organisation's attention and that organisation has had a reasonable opportunity to investigate and reply to the complaint ***(Local Government Act 1974 section 26(5), as amended and Health Service Commissioners Act 1993, section 9(5)).*** However, in the case of joint complaints (i.e. those deemed suitable for investigation by the Joint Working Team operated by both PHSO and LGSCO), if one organisation has investigated and replied to the complaint but another organisation has not, the Ombudsmen may decide to exercise their discretion to investigation the complaint against all organisations, so that the issues can be considered in the round.

5. The Ombudsmen investigate complaints about 'maladministration' and 'service failure'. We use the word 'fault' to refer to these. If there has been fault, the Ombudsmen consider whether it has caused injustice or hardship ***(Health Service Commissioners Act 1993, section 3(1) and Local Government Act 1974, sections 26(1) and 26A(1), as amended).***

6. When investigating complaints, if there is a conflict of evidence, the Ombudsmen may make findings based on the balance of probabilities. This means that during an investigation, we will weigh up the available evidence and base our findings on what we think was more likely to have happened.

7. If the Ombudsmen are satisfied with the actions or proposed actions of the bodies that are the subject of the complaint, they can complete their investigation and issue a decision statement ***(Health Service Commissioners Act 1993, section 18ZA and Local Government Act 1974, section 30(1B) and 34H(i)).***

How I considered this complaint

8. I read the correspondence Mr A sent to the Ombudsmen and asked him about his concerns via email. I wrote to all the organisations to explain what I intended to investigate and to ask for comments and copies of relevant records. I considered all the comments and records they provided. I also got copies of records from Mrs R's previous GP surgery, and from her hospital admission in January 2016.

9. I read relevant legislation and guidance and got advice from a clinical adviser: a GP with relevant knowledge and experience.

10. I shared a confidential copy of my draft decision with Mr A and all the organisations to explain my provisional findings. I invited their comments considered the remarks and additional information I received in response.

What I found

Background

Mrs R's living arrangements before she moved to the Care Home

11. Until August 2014 Mrs R lived with one of her sons, Mr C, who supported her. York Council also arranged for carers to visit Mrs R three times a day. In August 2014 Mr C went into hospital and Mrs R moved in to a care home in York (the York Home) as a temporary, respite measure. However, Mr C remained unwell and Mrs R stayed in the York Home. She was registered with a local GP (the York GP) throughout this time.

12. Mr C sadly died in July 2015. Mrs R's family and professionals agreed she would not be able to cope at home on her own. Mrs R wanted to move closer to her family. Her grandson spoke to York Council and noted Mrs R wanted to move to the Care Home. The Care Home told York Council it could meet Mrs R's needs.

York Council's assessment of Mrs R's needs

13. York Council completed an assessment of Mrs R's social care needs and a support plan in August 2015. This noted, among other things:

- Mrs R had some short term memory loss but could communicate her needs and preferences. However, it said:
    - She underestimated the amount of care she needed
    - Had difficulty retaining information and needed to be reminded.
- Mrs R experienced some incontinence and wore pads, and needed prompting to change the pad during the day if it was wet.
- Staff needed to prompt and assist Mrs R with personal care and hygiene tasks, including:
    - To assist her in the shower with appropriate equipment
    - To monitor her skin.
- Mrs R needed to receive a healthy, varied diet, and staff should:
    - Include low fat options
    - Encourage her to eat healthier options
    - Monitor her weight.

14. Toward the end of August 2015 Mrs R's grandson told York Council he was happy with its assessment. York Council sent copies of its assessment and support plan to the Care Home the following day.

Mrs R's move to the Care Home

15. Mrs R moved to the Care Home on 1 September 2015. The Practice registered Mrs R as a patient two days later.

Complaint that the Care Home failed to investigate Mrs R's complaint of being attacked in her bedroom

Arrangements at the Care Home

16. The Care Home said Mrs R's room was on the first floor of the building. It said at night there are normally three carers working, plus a senior. The Care Home said two of the carers work on the first floor.

Care Home's night time care plan

17. The Care Home completed a range of care plans for Mrs R at the start of September 2015. This included one about night care. The Care Home recorded that Mrs R wanted staff to check on her every two hours during the night. The plan also said Mrs R could let staff know when she needed support and could use the call bell.

18. The Care Home records state that night staff regularly checked on Mrs R at midnight, 2am, 4am and 6am.

Care Home records about events on 8 September 2015

19. The Care Home's records state Mrs R pushed her call bell shortly before midnight on 8 September 2015 as she was uncomfortable. Staff went to her room and inflated her mattress while Mrs R sat in a chair. Staff then helped her back to bed. Staff returned at 4am and found Mrs R to be sleeping.

20. At 6am Mrs R told a staff member that someone had come into her room in the middle of the night and pushed her to the floor. The staff member checked Mrs R for injuries and did not find any. They also told Mrs R that a carer had been upstairs all night and would have heard something if it had occurred. Later in the morning Mrs R told a different carer that somebody had been in her room at night and hit her on the back of the head and she had fell and hit the front of her head. The staff member checked the back of her head and face but did not find any marks or wounds.

Contact with York Council

21. York Council's records show the Care Home called it the next day. The Care Home told York Council what Mrs R had said, and noted that her recollection of events had changed. The Care Home noted that Mrs R's grandson's wife had checked Mrs R and it said there was no sign of any bruising or injury. The Care Home also said its staff had not heard or seen anything.

Care Home records about events over the following days

22. The records from the following days do not have any further reference to this incident, or any other concerns from Mrs R about her safety. There are entries about Mrs R asking staff to take her to her room. There are records that staff continued to regularly check on Mrs R throughout the nights and found her to be sleeping. In addition, there is evidence that Mrs R used the call bell to ask for assistance when she wanted it – for a drink, or to go to the toilet, or to complain that her bed was uncomfortable.

23. The Care Home records do not contain references to Mrs R showing any anxiety about going to bed, or about staying in the same room. There is evidence to show that staff locked the door when she asked for this.

Guidance about patient safety

24. There are standards for safety and quality care homes need to meet, which I will call the Regulations (***The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014***). The Care Quality Commission (the CQC) has written guidance to help care homes meet these standards, known as the Fundamental Standards (***Guidance for providers on meeting the regulations, March 2015***). This includes keeping people safe from risk or harm (***Regulation 12***).

Analysis

25. The Care Home's records show staff talked to Mrs R about this incident and regularly checked on her. There is also evidence that Mrs R was capable of, and willing to, ask for help when she wanted it, and of telling staff about her concerns. Mrs R did report said she had trouble sleeping after this incident, but this related to the comfort of the bed rather than any anxiety about a risk of harm. Records from later in the year show Mrs R did tell staff when she was in pain at times. Overall, given the absence of any evidence of a physical injury it was reasonable that the Care Home did not carry out an investigation of this incident. Therefore, I have not found any evidence of fault.

Complaint that the Care Home and Practice failed to address Mrs R's deteriorating health during December 2015 and January 2016

Mrs R's health before she moved to the Care Home

26. Mr A said Mrs R had Chronic Obstructive Pulmonary Disease (COPD) and was a little overweight, but was otherwise in good health. Further, he said before her move to the Care Home Mrs R had a good appetite and ate normally. He also noted that, before the move, Mrs R had complained of pains in her lower left abdomen.

Events while Mrs R was in the York Home

27. The York Home contacted the York GP in July 2015 and asked for indigestion treatment for Mrs R. The York GP prescribed medication and said the York Home should ask for a medical review if the symptoms persisted. A couple of days later Mrs R's family asked for a medical review as Mrs R had been burping and having discomfort in her stomach. The York GP saw her the following week and noted the problem had been ongoing for some time but was getting worse. They advised Mrs R to stop taking a medication and asked for an abdominal ultrasound.

28. Mrs R had the ultrasound scan in late August 2015. However, the sonographer said it had been difficult to perform the examination so the scan had limited use as a diagnostic tool.

Records the Care Home kept

29. The Care Home weighed Mrs R the day after she moved in and found her to be 104.1kg. It recorded this on a 'Weight Monitoring Chart' which it updated during Mrs R's admission.

30. The following day the Care Home started a 'Food and Nutrition Record' for Mrs R. This recorded information about the food and portion sizes it offered, and what

Mrs R ate. It recorded this information for: breakfast; morning snack; lunch; afternoon snack; tea; and supper. Staff completed this each day.

31. Staff also made regular entries on the Care Home's 'Daily Notes'. These notes included entries about:

- Mrs R's mood
- What she did during the day
- Whether she had eaten well or not had much to eat
- The type of care and support staff gave (or offered) Mrs R
- Concerns Mrs R or staff had about her health.

Relevant events in September 2015

32. The Practice saw Mrs R for the first time in the middle of September 2015. It did not yet have the records from the York GP, other than some the Care Home provided. The Practice noted Mrs R was belching a lot and that this was an ongoing issue.

Relevant events in October 2015

33. A GP from the Practice saw Mrs R again at the start of October 2015. They noted Mrs R had occasional spasms of stomach pain and had not opened her bowels for a few days. The GP examined Mrs R and thought she might be constipated and have colic (pain in the upper abdomen). The GP prescribed Buscopan (a medication to ease stomach cramps). They also asked the Care Home to see how things developed over the next few days and, if Mrs R got more unwell, to ask for another review.

34. The Care Home weighed Mrs R again in early October 2015 and found her to be 96.9kg (a decrease of 7.2kg over 34 days).

35. On 12 October 2015 staff in the Care Home felt Mrs R seemed unwell, was not moving as well and was not eating or drinking much. They asked a GP to see her. The GP examined Mrs R but did not find anything unusual. They prescribed a laxative and asked for a blood test. A couple of days later Mrs R complained of pain in her abdomen and told staff it felt '*like her insides were twisted*'.

36. On the same day Mrs R's grandson contacted York Council and said Mrs R had not settled in well. He said she had been confused at times, as well as paranoid and fearful. He also said her mobility and balance had deteriorated. Mrs R's grandson said he felt Mrs R may need an updated assessment at some point.

37. The Care Home weighed Mrs R again the next day and recorded her weight as 93.7kg (a decrease of 3.2kg over nine days, and 10.2kg over 43 days).

38. Mrs R complained of similar pain again the following week and staff noted she had not eaten much and her mobility seemed poor. Staff spoke to a GP at the Practice and said the Buscopan had helped a lot. The GP approved another prescription.

39. Toward the end of October 2015 the Care Home contacted the Practice again. They noted Mrs R had lost weight and said the Buscopan did not seem to be working anymore.

Relevant events in November 2015

40. A GP visited at the start of November and noted the amount of weight Mrs R had lost between the start of September and middle of October. They also noted

Mrs R was still complaining of wind and belching and was refusing to eat. The GP examined Mrs R but did not find anything to explain her symptoms. The GP referred Mrs R to a geriatrician for further investigation, to help find a cause of her continued abdominal pain and weight loss.

41. On the same day Mrs R's grandson spoke to York Council. He noted Mrs R was eating very little. He also said she was paranoid and yelped and flinched and put her hands up to her face if anyone came near her. Mrs R's grandson said Mrs R had deteriorated significantly, including her mobility and mental health.

42. York Council also spoke to the Care Home. The Care Home noted it had food and fluid charts in place and were in contact with the GP who had, in turn, referred Mrs R to a geriatrician. York Council spoke to Mrs R's grandson again and he said he felt it was appropriate to wait for the outcome of the referral to the geriatrician to see if this ruled out a clinical cause and, if it did, they could then consider a mental health assessment. York Council also noted that Mrs R's grandson was happy with the care at the Care Home and felt a move would be detrimental to Mrs R's health.

43. The Care Home weighed Mrs R again on 6 November 2015 and she weighed 91.1kg (a decrease of 2.6kg over 22 days, and 13kg over 65 days).

44. At the end of November 2015 York Council spoke to the Care Home which advised that things were pretty much the same. The Care Home said it was continuing to monitor how much Mrs R ate and drank. It also noted that Mrs R had not yet seen the geriatrician.

Relevant events in the Care Home in December 2015 and early January 2016

45. Mrs R continued to eat only small amounts of food in December 2015, and sometimes refused to eat anything. This was in the Care Home and when Mrs R went out: Mrs R's grandson took Mrs R out in early December 2015 and told staff they had encouraged her eat at their house but she had not eaten anything.

46. A couple of days later the Care Home called the Practice due to their concerns about how little Mrs R was eating. A GP said Mrs R needed to see the geriatrician as they had done as much as they could to investigate her symptoms locally. The GP said they would chase the referral.

47. On 13 December 2015 staff asked for a GP review because of general concerns about Mrs R's health. The staff member recorded in the Care Home notes that Mrs R was '*not right*'. They also recorded in the daily notes that Mrs R was still complaining of pain in her stomach and still not eating. The GP saw Mrs R the next day. They noted Mrs R's breathing was '*not as good*' and examined her. They did not find anything to explain Mrs R's symptoms and noted again that she was due to have an outpatient appointment with a geriatrician. Over the following days the Care Home noted that Mrs R periodically threw herself back and forth and complained of pain in her stomach.

48. On 21 December 2015 the Care Home called an ambulance which took Mrs R to hospital. The hospital diagnosed Mrs R as suffering from urinary tract and kidney infections and noted she was dehydrated. It gave Mrs R a course of antibiotics, encouraged her to drink and discharged her the same day.

49. The Care Home weighed Mrs R again on 23 December 2015. She weighed 82.5kg (a decrease of 8.6kg over 47 days, and 21.6kg over 112 days). The following day staff advised the Practice that Mrs R continued to eat and drink very little.

50. The Care Home updated its care plans for Mrs R on 28 December 2015. It noted she continued to have the mental capacity to tell staff what she liked and did not like. The care plans noted Mrs R had minor problems with chewing and swallowing. It advised staff to encourage and assist Mrs R to eat.

Admission to hospital on 3 January 2016

51. Mrs R went to stay with her family on 2 January 2016. They called an out of hours doctor the following evening due to Mrs R's abdominal pain. Mrs R went to hospital which noted she had an acute kidney injury and treated her with IV fluids.

52. Mrs R had a CT scan on 6 January 2016 and this showed her to be faecally loaded. The following day medics noted concerns about Mrs R's ability to swallow safely. They said she should not be given food or drink orally and asked Speech and Language Therapy (SALT) to review her. This review happened the next day and SALT recommended a pureed diet and thickened fluids.

53. Mrs R remained in hospital until she sadly died on 21 January 2016.

Relevant guidance

54. Health and social care staff should presume people have the mental capacity to make choices about their own care unless there is proof to the contrary. People should not be treated as lacking capacity just because the decisions they make are unwise ones (***Section 1, Mental Capacity Act 2005***).

55. Care homes need to provide personalised care, respect peoples' wishes and ensure they only provide care and treatment with the person's consent. As part of this, care homes should assess peoples' needs, taking account of their own views and preferences, and keep these assessments under regular review (***Regulations 9, 10 and 11***).

56. Care homes also need to make sure their residents get enough to eat and drink. As part of this requirement, care homes need to keep a person's food and drink needs under review. When things change, and when a person is not eating or drinking enough, staff need to act (***Regulation 14***).

Analysis

57. The Care Home's records show staff regularly checked on Mrs R and noted changes to her health and eating habits. They also show that staff were conscious of, and concerned about, Mrs R's weight loss.

58. Mrs R was never considered to lack the mental capacity to make her own choices, including about what she would or would not eat. The Care Home needed to respect Mrs R's own choices and could not force her to eat. There is evidence to show that staff tried offering different types of food, and encouraged Mrs R to eat and drink. The Care Home also sought help from medical professionals to try to find a cause for Mrs R's behaviour and pain, by involving the Practice.

59. The Practice records show GPs reviewed Mrs R in good time when the Care Home asked for this. Mrs R's weight loss was significant. There was a basic explanation for this – that Mrs R was not eating. Mrs R was also noted to be constipated and this can sometimes make people less inclined to eat. The GP requested blood tests to try to find an explanation for what was happening, but the results did not provide an answer.

60. The significance of Mrs R's weight loss meant further action was necessary. The Practice did act by referring Mrs R to a geriatrician. This was appropriate.

61. It is established practice to allow secondary care to consider whether to undertake different types of investigations. Some can be invasive and be stressful, both physically and mentally, and it is appropriate for a consultant to weigh up the pros and cons with the person (and their family) as they have more specialist experience. Therefore, it was reasonable for the Practice to have left it for secondary care to have considered these matters.

62. However, Mrs R did not get to see a geriatrician. The Practice had asked for an appointment 'soon', as opposed to urgently. This was appropriate in the circumstances, as physical examinations and blood tests had not suggested anything sinister as a cause for Mrs R's weight loss. There are no set standards for how long it should take to get an appointment following a 'soon' referral. It can vary around the country and between disciplines. As a general guide the referrer might expect the person to be seen within four to eight weeks.

63. The Practice said when it made the referral to the geriatrician there was nothing to indicate there was likely to be a wait of more than a few weeks. It said the hospital asked it to email the original referral letter to them on 27 November 2015, and it did so. The Practice said it chased things up on 8 December and again on 29 December 2015. It said that it was at this point that the old age service indicated the waiting time was likely to be eight to ten weeks. During the complaints process the hospital noted there had been a 'clinic capacity issue' which meant it could not offer an appointment earlier than 6 January 2016. The hospital apologised for this.

64. A month after the Practice made the referral Mrs R had not shown any signs of improvement. In addition to asking the secretaries to chase things up a GP could have written a letter to geriatrician asking for the referral to be expedited as Mrs R had not improved after a month. However, throughout this time, there was nothing in the GP's examinations or the blood tests which indicated Mrs R needed an urgent, acute admission. At one point blood tests showed some renal impairment but this improved at a later test and returned to an acceptable level. A test also suggested Mrs R might be slightly anaemic but, again, this returned to a normal range at the next test. It is also notable that Mrs R went into hospital toward the end of December 2015 but it did not find she needed to stay in hospital. Therefore, there had been no indication Mrs R needed an acute hospital admission before she went at the start of January.

65. If a GP had written to the geriatrician after a month I do not know whether this would have sped things up as the geriatrician's caseload was out of the Practice's hands. Further, the investigations the geriatrician could have asked for were done during Mrs R's hospital admission and did not identify a clear cause for her problems. Mrs R was found to be constipated, but scans and examinations did not identify any other explanation for Mrs R's deterioration and weight loss. The Practice had known Mrs R was constipated in the community and they had prescribed an appropriate treatment for this. As such, while the Practice could have been more proactive in chasing the referral it made to secondary care, it is not clear this would have led to a different outcome.

66. Overall, there is evidence to show the Care Home monitored Mrs R's health appropriately and asked for suitable medical help. The Practice completed relevant examinations and tests and, again, made a suitable referral. Therefore, I have not found evidence of fault.

Complaint the Care Home failed to provide proper personal care for Mrs R

Records the Care Home kept

67. The Care Home completed care plans for Mrs R a couple of days after she moved in. It noted she was occasionally incontinent of urine and may need a carer to help her to use the toilet.

68. Staff recorded the ways they supported Mrs R in the Daily Notes. This included entries about:

- Helping with personal care
- Helping to get dressed
- Washing
- Helping Mrs R to the toilet
- Changing continence pads.

69. On 21 December 2015 staff noted another full body wash and reported that Mrs R was sore and red. They applied a cream and informed a senior member of staff.

70. The Care Home updated its care plans on 28 December 2015. It noted that two members of staff needed to help Mrs R to the toilet due to poor mobility. The Care Home also noted that Mrs R needed full assistance with general bathing and personal hygiene. On the same day staff noted they were checking all of Mrs R's pressure areas every day and would report any concerns to the senior member of staff on duty who would then inform the community nurses if necessary.

71. The following day staff noted that Mrs R was still looking red and they applied more cream.

Relevant records from Mrs R's hospital admission

72. On 4 January 2016 hospital staff noted two stage two sores to Mrs R's left and right buttocks, and a stage three sore on her natal cleft. A couple of days later staff noted a '*significant moisture lesion to sacrum, both buttocks*'.

Analysis

73. The Care Home records show that Mrs R's need for help and support increased during her time in the Care Home. There are entries from the early part of her stay which report her going to the toilet on her own but, later, she could not manage this. The records also show that staff regularly checked on Mrs R and offered to help her wash, dress and go to the toilet. There were a number of occasions when Mrs R told staff she did not want any help. In keeping with the Regulations, staff were right to respect Mrs R's wishes.

74. Pressure sores and moisture lesions can occur very quickly, over a matter of hours. This means the evidence from the hospital does not automatically show Mrs R's sores came from her time in the Care Home. Nevertheless, Mrs R's mobility was known to have reduced, she was incontinent, sometimes refused to let staff change her pads or wash her, and had a poor diet. These are known risk factors for the development of pressure sores and moisture lesions. Therefore, on the balance of probabilities, the sores the hospital found related to the time she was in the Care Home.

75. However, this is not to say the sores only arose because of poor care by the Care Home. Entries in late December 2015 provide evidence that staff did wash Mrs R thoroughly. They took note of changes to her skin and responded to this. The Care Home updated the relevant care plan and there is evidence that staff were

aware of the need to check on areas of Mrs R's skin which were susceptible to pressures sores. There is also evidence to show the Care Home used a pressure relieving mattress and pressure cushions. Therefore, there is sufficient evidence to show the Care Home offered appropriate support for Mrs R's needs, but she did not always want to accept it.

Complaint the Practice failed to recognise signs the Care Home was not providing proper personal care for Mrs R.

Response from the Practice

76. In response to this complaint, the Practice said the Care Home, Mrs R and the family did not advise it of any pressure sores or moisture lesions. It said GPs always saw Mrs R for a defined problem and undertook relevant examinations. It said its GPs limit their examinations to areas of the body which are relevant to the clinical concerns they are dealing with at the time.

Analysis

77. The Practice's response is in line with established good practice for GP visits. When GPs complete home visits the person who requested the visit advises of a problem and the GP completes a targeted examination. There is no expectation for a GP to undertake a complete, head-to-toe examination of patients every time they see them. Also, GPs generally do not get very involved in issues around skin integrity and pressure areas. Nurses have the relevant skills and expertise for these issues. Therefore, I have not found any evidence of fault here.

Complaint the Care Home failed to provide proper pressure area care

Relevant events while Mrs R was in the Care Home

78. The Care Home recorded that a community nurse saw Mrs R on 24 December 2015 and looked at a wound on her left foot. The notes said the nurse thought it looked like a blister and, as it was dry, advised against putting a dressing on it. A couple of days later a member of staff noted a '*bruised looking circle on [Mrs R's] left heel*'. They notified a senior member of staff.

Relevant records from Mrs R's hospital admission

79. On 4 January 2016 the hospital noted a stage three pressure sore (measuring 2.5cm by 2.5cm) on Mrs R's heel. It described this as 100 percent necrotic. A member of staff called the Care Home which said this related to a slipper.

Guidance on pressure area care

80. All adults are at risk of developing pressure sores and there is guidance about helping to prevent them. The National Institute for Health and Care Excellence (NICE) issued its guidance in April 2014, which I will refer to as the NICE Guidance (***NICE Clinical Guideline 179 – Pressure Ulcers: prevention and management (April 2014)***). This includes advice that staff should discuss '*with adults who are at high risk of developing a heel ulcer a strategy to offload heel pressure*' (***section 1.1.15***).

Analysis

81. I have not seen evidence in the Care Home records to show that it took sufficient proactive steps to help prevent this sore from forming. Records show staff were aware of a mark on Mrs R's heel. The hospital notes provide evidence that staff felt it related to her slippers. However, I have not found any entries in Mrs R's notes or care plans about taking steps to alleviate pressure on this area. This is fault. A plan, which could have included the use of specific equipment or advice about regular repositioning of this area, could have helped to prevent the sore

Mrs R had. The sore was painful and distressing for Mrs R, and distressing for other to see. Therefore, on the balance of probabilities, this fault led to an injustice.

Complaint that Notts Council failed to investigate his concerns adequately or objectively

Notts Council's investigation of Mr A's concerns

82. Mr A contacted the Care Quality Commission (the CQC) and raised concerns about the way the Care Home had cared for his mother. In early April 2016 the CQC referred these concerns on to Notts Council as a safeguarding matter.

83. Notts Council checked whether its social care team had any previous contact with Mrs R, and checked if any safeguarding concerns had been raised earlier. It checked with its Quality Market Management Team and noted they did not have any current concerns about the Care Home. Notts Council also checked the CQC website and found the last inspection had rated the Care Home as 'Good'.

84. In the middle of April 2016 a Safeguarding Social Worker visited the Care Home. Later in the month she spoke to a GP at the Practice and asked about their involvement in Mrs R's care. The Social Worker went to the Care Home again in early May and looked at the records and spoke to the manager. The Social Worker also visited a hospital and read through the records of Mrs R's admission to hospital in January 2016.

85. Notts Council closed its safeguarding enquiry as 'inconclusive' and said it had not identified any risk.

Analysis

86. Evidence shows Notts Council obtained information from an appropriate range of sources to form an understanding of what happened while Mrs R was in the Care Home. The case notes show the Social Worker used her judgement to analyse this information. Therefore, there is evidence to show the Council followed the process appropriately and I have no reason to question the professional judgement of the Social Worker. I find no fault.

Agreed actions

87. Within one month of the date of the final decision York Council (as the organisation responsible for arranging Mrs R's care) should write to Mr A to acknowledge they did not provide suitable pressure area care in respect of Mrs R's heel. They should also acknowledge that, as a result, Mrs R developed a pressure sore to her heel which caused her and her family distress. York Council and the Care Home should apologise for this distress.

88. Within two months of the date of the final decision York Council should arrange for the Care Home to complete an action plan to ensure lessons are learned from this complaint, and to help prevent recurrences. The Care Home should share this with York Council and the Ombudsmen.

Decision

89. I have completed my investigation on the basis that:

- There was no fault in the actions of the Care Home after Mrs R complained of being attacked in her room.

- There was no fault in the way the Care Home and Practice responded to Mrs R's deteriorating health during December 2015 and January 2016.
- There was no fault in the Care Home's management of Mrs R's personal care needs.
- There was no fault on the part of the Practice in relation to Mrs R's personal care needs.
- There was fault in the pressure area care Mrs R received in the Care Home and this led to an injustice. I have recommended an apology and action plan to address this injustice.
- There was no fault in the process Notts Council in investigating Mr A's complaint.

Investigator's decision on behalf of the Ombudsmen

23 March 2018

Complaint reference:
16 012 732

Complaint against:
Nottinghamshire County Council

Local Government OMBUDSMAN

The Ombudsman's final decision

Summary: Miss X complains about the Council's decision to end her personal budget. The Ombudsman found the Council was at fault in the way it assessed her needs and dealt with her complaint but not in ending her support. This caused her distress so it will offer her a reassessment, pay her £150, improve the way it completes assessments and review its training.

The complaint

1. The complainant, whom I shall refer to as Miss X, complains that the Council:

a) failed to properly complete an assessment of her needs;

b) used inaccurate and out of date information when completing assessments and based its decision to withdraw her personal budget on this;

c) failed to deal effectively with her complaint about this; and

d) failed to comply with the local information sharing protocol and data protection requirements in that it:

1. accessed her records inappropriately;
2. did not advise her about all the places where her information was recorded;
3. inappropriately shared her information between the health service and social care.

2. Miss X says this has had a substantial negative effect on her mental health and wellbeing and would like the Council to complete an accurate assessment.

What I have investigated

3. I have investigated parts a – c of Miss X's complaint listed above. My reasons for not investigating part d of her complaint are at the end of this decision statement.

The Ombudsman's role and powers

4. We investigate complaints of injustice caused by maladministration and service failure. I have used the word fault to refer to these. We cannot question whether a council's decision is right or wrong simply because the complainant disagrees with it. We must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, section 34(3), as amended)***

5. If we are satisfied with a council's actions or proposed actions, we can complete our investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

6. I considered information from the complainant and from the Council.

7. I sent both parties a copy of my draft decision and revised draft decision for comment and took account of the comments I received in response.

What I found

Background

8. Sections 9 and 10 of the Care Act 2014 require councils to carry out an assessment for any adult who appears to need care and support. They must provide an assessment to all people regardless of their finances or whether they think the person has eligible needs. The assessment must consider the person's needs, the impact on their wellbeing, and the results they want to achieve. It must also involve the individual and their carer or any other person they might want involved if appropriate.

9. The statutory guidance says:

- In carrying out a proportionate assessment local authorities must have regard to:
- a) The person's wishes and preferences and desired outcomes. For example, an individual who pays for their own care may wish to receive local authority support with accessing a particular service, but may not want the same interaction with the authority as someone who wants greater support.
- b) The severity and overall extent of the person's needs. For example, an individual with more complex needs will require a more detailed assessment, potentially involving a number of professionals. A person with lower needs may require a less intensive response.
- c) The potential fluctuation of a person's needs, both adults and carers. For example, where the local authority is aware that an adult's needs fluctuate over time, the assessment carried out at a particular moment may take into account the adult's history to get a complete picture of the person's needs. (6.42)
- "Each local authority may decide to use an assessment tool to help collect information about the adult or carer and details of their wishes and feelings and their desired outcomes and needs. Where a local authority has decided that a person does not need a more detailed assessment, it should consider which elements of the assessment tool it should use and which are not necessary". (6.43)

10. The Care and Support (Eligibility Criteria) Regulations 2014 set out the eligibility threshold for adults with care and support needs. The threshold is based on how a person's needs affect their ability to achieve relevant outcomes, and the impact on their wellbeing. The eligibility criteria are applied after the assessment and without regard to whether a carer is meeting needs at the time. To have needs which are eligible for support, the following must apply:

    1. The needs must arise from or be related to a physical or mental impairment or illness.
    2. Because of the needs, the adult must be unable to achieve two or more of the following:
        a. Managing and maintaining nutrition.
        b. Maintaining personal hygiene.
        c. Managing toilet needs.
        d. Being appropriately clothed.
        e. Being able to make use of the adult's home safely.
        f. Maintaining a habitable home environment.
        g. Developing and maintaining family or other personal relationships.
        h. Accessing and engaging in work, training, education or volunteering.
        i. Making use of necessary facilities or services in the local community including public transport, and recreational facilities or services.
        j. Carrying out any caring responsibilities the adult has for a child.
    3. Because of not achieving these outcomes, there is likely to be, a significant impact on the adult's well-being.

11. Where local authorities determine a person has eligible needs, they must meet these needs. When a local authority decides about a person's eligibility, it must give the person a copy of its decision. If a person has no eligible needs it must provide information and advice about what is available to prevent, meet or reduce needs that are not eligible.

12. The following requirements of the Care Act 2014 (the Act) are also relevant to this case. Councils must:

    - assume the individual is best placed to judge their wellbeing;
    - focus on the person's needs and outcomes they want to achieve;
    - take a person centred approach to assessment and balance the person's own view with that of others;
    - offer supported self assessments if the person is willing and able. The person should be in control and should complete the assessment; and
    - "Where a person has both health and care and support needs, local authorities and the NHS should work together effectively to deliver a high quality, coordinated assessment". ***(Care and support statutory guidance 6.78)***

13. The Council's "Assessment, Eligibility, Support Planning & Personal Budgets Guidance" says:

    - "We have a duty to offer a supported self-assessment" (4.1).

- "We continue to have a duty to involve the service user in their assessment" (4.1).
- "We have a duty to ensure the assessment is in proportion to the presenting needs". "[The system] will automatically pull through information to the care and support assessment and this must be used as the starting point for further work. You are not expected to go over the same information again" (4.2).
- "In order to make sure the assessment is **appropriate**, it must be person-centred, collaborative and involve a transparent and understandable process" (4.3).

What happened

14. Miss X has difficulties with anxiety and depression. This affects her day to day life and restricts her activities significantly. She has been unable to work for some time and received a personal budget which she used to pay for someone to accompany her to a weight advice group.

15. On 7 December 2015, Officer 1 from the Council assessed Miss X's social care needs. On 16 December Officer 1 advised Miss X that she had decided not to award her a personal budget and the support she had been receiving would therefore end.

16. Following several telephone calls between Miss X and Officer 1, Miss X complained about the assessment in April 2016. The points she raised included:

- Officer 1 did not offer her the opportunity to complete a self-assessment.
- She disagreed with some of the information and how Officer 1 had decided the outcome. However, Officer 1 did not change it or give her the opportunity to discuss it, or the outcome, before she completed the assessment.
- The form said Miss X did not need independent support at the time of the assessment. Miss X says her mother provides daily support without which she could not have attended the assessment.
- The form included information about a problem she had over twenty years previously; this was not relevant to the assessment.
- The form says "any differences of opinion will be recorded in the Assessment Summary"; there is a space headed "Differences of opinion" in this section. None of the information entered at this point addressed Miss X's differences of opinion and introduced further information with which Miss X disagreed.
- Miss X says that Officer 1 did not offer her mother a carer's assessment and did not check whether she was willing to continue providing support.
- Officer 1 provided Miss X with details of groups and resources that would be suitable to meet her needs. Miss X says she had already been to several of these but most were not suitable. She says she cannot access those that might help without support.
- Miss X also asked Officer 1 why she had not spoken to anyone else involved in her care for example, her therapist.

17. Having already completed the assessment and told Miss X the outcome, Officer 1 contacted her therapist. The therapist advised Officer 1 that Miss X found the support useful and asked if she could extend the funding for three months so she could help Miss X cope without. Officer 1 said this was not possible. The therapist noted "the effect of the withdrawal of the financial support has been to leave

[Miss X] feeling disregarded and judged". Officer 1 recorded this and her other comments on the assessment form, though she had advised Miss X it would not change the decision. In response to my draft decision, the Council said it would have changed the decision if the information had been significant. It says the assessment was proportionate to the two and a half hours weekly support provided to Miss X.

18. Officer 1 ticked the box that said "I confirm that I have checked and approved the contents of this assessment". Miss X says she did not approve and had not had the opportunity to check the contents before it was completed.

19. On 18 May 2016, the Council responded to Miss X's complaint. It offered her a reassessment which Officers 3 and 4 carried out on 17 August 2016. The Council says Officers 3 and 4 are senior practitioners trained in mental health and based in a community mental health team. These officers also failed to offer a supported self assessment (SSA) in line with the Care Act. The Council says it is rare for SSA's to be completed for mental health users who usually prefer face to face assessments. It will apologise to Miss X for this.

20. The reassessment found she could not meet two or more of the outcomes without support but there would be no significant impact on Miss X's wellbeing if support were not provided. Officer 3 wrote "Our professional view is that there is not evidence that [the personal budget] is having a significant impact on [Miss X's] wellbeing".

21. On 20 October 2016, Officer 3 telephoned Miss X asking questions about issues they had discussed. Miss X says she felt this could have been done sooner than two months after the reassessment.

22. On 27 October 2016, Miss X and her mother met with Officer 1's manager, Officer 2, and an officer from the Council's complaints team, to discuss her complaint about the earlier assessment. Miss X listed 42 points to discuss and says the Council just selected some and did not ask her which points. However, as the meeting would be two hours, the Council advised her this would be too many points and asked her to choose the most important, which she did. The meeting had both the full list and priority list of points and discussion did not keep strictly to the agenda but responded to Miss X's points as she raised them.

23. On 1 November 2016, the Council advised Miss X of the outcome of her re-assessment which was that she was not eligible for a personal budget. Miss X was unhappy with this outcome and complained. She said:

- Information she had previously said was wrong or inappropriate was carried forward from the previous assessment and this must have influenced the assessors. It also included more excessive and irrelevant information. Her mobile telephone number was wrong even though she had advised one of the officers. The wrong medication was also listed.
- Officers 3 and 4 had taken support into account when answering some of the questions and had not considered the impact of her mental health condition.
- The length of time between the reassessment and her being advised of the outcome was unacceptable (two months in total).

24. The Council responded to Miss X's complaint and advised her on several occasions she could complain to the LGO. Miss X was unhappy with its response and on 17 January 2017 she wrote to the Council and said she would complain to the LGO. Miss X does not believe those dealing with her complaints properly

considered or dealt with her concerns because they accepted the view of the assessors. She says they did not consider whether there was any substance to Miss X's view.

25. The Council says all assessment staff attended a one day training course on the Care Act in 2015. An e-learning package is available and used by staff. Assessment also formed part of training delivered in 2017. It is currently developing assessment skills training.

Was there fault which caused injustice?

26. The Council decided Miss X was not eligible for support using the eligibility criteria set out in paragraph 10 above. There was no fault in this.

27. Its first assessment was flawed. It contained contradictory information, did not provide enough evidence for this decision and did not reflect Miss X's views. The Care Act and the Council's own guidance require a supported self assessment to be offered but it was not. The standard of this assessment fell below acceptable standards and did not comply with the Care Act 2014. This was fault and caused Miss X significant and avoidable distress. However, the Council completed a reassessment which was a suitable remedy for this injustice.

28. The reassessment form again contained out of date and inaccurate information. It did not clearly consider needs before the support Miss X says she received although I am satisfied the assessor did this. The form also failed to set out Miss X's own views and differences of opinion properly, and we cannot therefore, be certain they were properly considered. It also took two months to decide the outcome which is excessive. However, the reassessment included a reasoned written decision by the assessor, which I am satisfied was sound and, despite the flaws, unlikely to change.

29. Historic information is often pulled through into new forms to save entering the same information; this is standard practice and aids a proportionate assessment. The Council's guidance (paragraph 13) says assessors are expected to use the information pulled through and are not expected to go over the same information again. However, assessors are responsible for the content of the form. If information pulled through by the system is not relevant or is wrong, the assessor must remove or correct it. This was fault which also caused Miss X distress.

30. Both assessments included undated and irrelevant information and failed to properly reflect Miss X's views. Offering to have comments added to the record is a suitable remedy where information is disputed but a poor substitute for what should have happened in this case. It is essential that assessors include all relevant information and ensure information is accurate before assessments are completed. I cannot say however, that the outcome would have been any different.

31. Although the Council offered a suitable remedy for the injustice caused by the first assessment, it did not properly consider the issues she complained about. Miss X did submit numerous points of complaint which were difficult to address, but there were a few core issues it could have dealt with effectively and without delay. These included:

- How the form was completed and whether the options selected were accurate.
- Out of date and inaccurate information pulled through from previous assessments.
- Why Miss X was not offered a self assessment.

- Why her view was not reflected despite having communicated this clearly.

32. Had it addressed these issues adequately, they should not have been repeated with the reassessment, but they were. This was fault and caused Miss X significant and avoidable distress.

Agreed action

33. To put right the injustice the Council caused Miss X, I recommended it take the following action:

- Within one month of the final decision:

a) Apologize to Miss X setting out the faults identified above.

b) Pay Miss X £150 to reflect the distress it caused.

c) Offer Miss X a reassessment which should consider the findings above.

d) Add a copy of the final decision statement to Miss X's social care record (SCR).

e) Provide evidence of these actions to the Ombudsman. Suitable evidence would be a copy of the letter and payment, confirmation of the reassessment date, and that the final decision has been added to the SCR.

- Within three months of the final decision:

a) Take action to ensure supported self assessments are offered when appropriate, that information is relevant and current, and that the person's views are accurately reflected on the assessment.

b) Review the effectiveness of staff training and process guidance relating to the assessment form and ensure consistency and understanding of the process.

c) Provide evidence of these actions to the Ombudsman. Suitable evidence would include a copy of the action plan.

Final decision

34. I have completed my investigation and uphold Miss X's complaints that the Council:

a) failed to properly complete an assessment of her needs;

b) used inaccurate and out of date information when completing assessments and based its decision to withdraw her personal budget on this; and

c) failed to deal effectively with her complaint about this.

35. I am satisfied that the actions the Council has agreed will put right the injustice it caused as far as possible.

Parts of the complaint that I did not investigate

36. I did not investigate the following parts of Miss X's complaint that the Council:

d) failed to comply with the local information sharing protocol and data protection requirements in that it:

1. accessed her records inappropriately;
2. did not advise her about all the places where her information was recorded;

3. inappropriately shared her information between the health service and social care.

37. This is because Miss X has taken these complaints to the Information Commissioner and the NHS Information Governance unit who are better placed to consider these.

Investigator's decision on behalf of the Ombudsman

2 March 2018

Complaint reference:
16 017 384

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Council is at fault for the way it decided to restrict Ms X's contact with her adult son. Mr Y. However, I cannot say this has caused Ms X a significant personal injustice. There is no evidence of fault in the way Mr Y's care home investigated Ms X's complaint or that it is not meeting Mr Y's care needs. The Council has accepted certain case notes referring to Ms X do not make it clear what is professional opinion and what is fact. The Council has apologised and reiterated its guidance to the staff concerned, I consider this a suitable remedy.

The complaint

1. Ms X has defined her complaint as:

1. The manager at her adult son, Mr Y's, care home raised a malicious safeguarding alert against her, and:

- the Council failed to take appropriate action when she warned it she was about to have access between herself and Mr Y restricted unnecessarily. She says the Council should have allowed her to make the challenge before the next arrangement to see Mr Y. Therefore the Council did not act appropriately to prevent an unnecessary infringement of Ms X and Mr Y's human and family rights;
- when the Council's investigation revealed the care home manager was the decision-maker and the Council had misdirected Ms X about this, the Council failed to apologise to her, recognise the distress this had caused her or take steps to prevent this happening again; and
- the Council misinformed Ms X about who had responsibility for the decision to restrict access in the way it was carried out.

2. The investigation carried out by the care home's manager into the above events was flawed. This is because it was biased and failed to address the evidence and issues raised. The Council's review endorsed the bias by failing to discuss Ms X's views or consider the documents she submitted or offered to submit and failed to recognise the lack of objectivity in the care home's report. As a result, Mr Y remains at risk in the care home.

3. Ms X has evidence which shows the care home manager is failing in her duty of care towards Mr Y. She says the Council's actions are inadequate because it has refused to consider this evidence in its entirety. In addition, senior managers and the director are failing to communicate with her and are

inappropriately referring her to the complaints system about issues she needs to raise in relation to her Mr Y's care. This is leading to an inefficient, complicated and unworkable relationship with the Council.

4. Notes made by the social worker and the care home manager, which she has received as part of her subject access request, contain lies which is impacting on decisions made by other professionals. However, the Council is refusing to appropriately investigate her concerns.

What I have investigated

2. I have investigated the actions of the Council and Mr Y's care home.

The Ombudsman's role and powers

3. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***

4. We cannot question whether a council's decision is right or wrong simply because the complainant disagrees with it. We must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, section 34(3), as amended)***

5. If we are satisfied with a council's actions or proposed actions, we can complete our investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

6. I have spoken with Ms X and considered information she has sent in and her written complaint. I have also considered the Council's response to my enquiries.

7. I considered information from the council responsible for safeguarding Mr Y.

8. Ms X and the Council have had an opportunity to comment on my Draft Decision.

What I found

Safeguarding vulnerable adults

9. Councils play the lead role in co-ordinating work to safeguard adults. Anyone who has concerns for the welfare of a vulnerable adult should raise an alert. The Council's policy sets out the responsibilities of the people involved and the timescales for action.

10. The purpose of the safeguarding process is to:

- Find out the facts about what happened; and
- protect the vulnerable adult from the risk of further harm.

11. The Council's safeguarding policy and procedures set out how the Council will respond to allegations and concerns about abuse.

12. When someone raises a concern with the Council, it should undertake an initial enquiry to decide how to respond. If the Council does not resolve the concern

through initial enquiries it will need to investigate to decide on the most proportionate response.

13. If it decides to investigate the Council appoints a safeguarding investigating officer to find out what happened and to collate information from all the relevant parties. From this they prepare a safeguarding investigation report for discussion at a case conference. This is a multi-agency meeting, with all interested parties, to consider the findings of the investigation. The case conference will decide on the findings and whether abuse or neglect has occurred, assess risk, what future actions are needed and how these should be monitored.

14. It is not for the Ombudsman to reinvestigate the safeguarding referral but to consider whether the Council conducted a suitable investigation in line with its safeguarding procedures and the Care and Support statutory guidance.

Mental Capacity Act 2005

15. The Mental Capacity Act 2005 sets out five principles:

- A person must be assumed to have capacity unless it is established that they lacks capacity.
- A person is not to be treated as unable to decide unless all practicable steps to help them to do so have been taken without success.
- A person is not to be treated as unable to decide merely because they make an unwise decision.
- A decision made on behalf of a person who lacks capacity must be made in their best interests.
- Before deciding, the decision maker must have regard to the option least restrictive of the person's rights and freedom of action.

16. The Act also says the test of someone's capacity to decide is on the balance of probabilities and is decision and time specific. When someone makes a best interests decision on behalf of an adult who lacks capacity, they must consider the person's wishes, feelings, beliefs and values and those of family and friends.

17. If the Council feels an adult may not be able to decide about their care, it should carry out a Mental Capacity Assessment. This will assess the adult's capacity to make a particular decision at the particular time it needs to be made.

18. As part of the Mental Capacity Assessment the Council may consider appointing an Independent Mental Capacity Advocate (IMCA) to support the person to take part as fully as possible in decisions about their life.

Deprivation of Liberty Safeguards (DoLS)

19. The Deprivation of Liberty Safeguards (DoLS) provide legal protection for individuals who lack mental capacity to consent to care or treatment and live in a care home, hospital or supported living accommodation.

20. The DoLS protect people from being deprived of their liberty, unless it is in their best interests and there is no less restrictive alternative. The legislation sets out the procedure for getting authorisation to deprive an individual of their liberty.

21. Without authorisation, deprivation of liberty is unlawful. It is the responsibility of the care home or hospital to apply for authorisation. The 'managing authority' of the care must request authorisation from the 'supervisory body' (the Council). There must be a request and an authorisation before a person is lawfully deprived of his or her liberty.

22. There are two types of authorisation. Urgent authorisations are made by the managing authority of the care home, for seven days, pending application for a standard authorisation. Standard authorisations are made by the Council.

23. On application, the supervisory body must carry out assessments of the six relevant criteria: age, mental health, mental capacity, best interests, eligibility and 'no refusals' requirements. A minimum of two assessors, usually including a social worker or care worker, sometimes a psychiatrist or other medical person, must complete the six assessments. They should do so within 21 days, or, where an urgent authorisation has been given, before the urgent authorisation expires.

24. When an authorisation is given, a Relevant Person's Representative (RPR) must be appointed and put in writing. The RPR must be in regular contact to make sure decisions are made in the person's best interests. The supervisory body must advise the RPR of the reasons for the authorisation and the duration.

What happened

25. Ms X's adult son, Mr Y, is autistic and has severe learning difficulties. Mr Y has lived, as an adult, in a care home setting since 2003. In 2013 he moved to his current care home, the care home. Mr Y usually stays with Ms X at her home every third weekend and meets her for lunch in between visits. The Council commissioned Mr Y's care and is responsible for the actions of the care home. However, the home is outside of the Council area so the council where the home is located, the Safeguarding Council, is responsible for Mr Y's safeguarding.

26. Mr Y has been assessed as having no mental capacity to decide about his care or where he lives. Because of this a DoLS authorisation is in place for Mr Y. In May 2016 a new DoLS was authorised and Mr Y's father, who is separated from Ms X, was appointed as Mr Y's representative.

27. On 15 July 2016 the care home manager reported an incident to the Council. She said Mr Y had an abscess and had a dentist appointment booked. The manager had called a doctor to discuss pain relief for Mr Y. Mr Y's case notes show the doctor issued a prescription for reduced strength codeine. Mr Y had taken paracetamol at 3pm so the doctor said Mr Y should not take the codeine until 5pm.

28. The manager relayed this information to Ms X. Ms X became concerned the manager was not giving Mr Y the correct dosage which would have meant Y was at risk of an overdose. The manager confirmed to Ms X and the Council she had delivered the prescription as prescribed.

29. Following Mr Y's dental appointment the manager contacted the Safeguarding Council to raise a safeguarding alert. The manager was concerned about Ms X's ability to care for Mr Y. The manager cited several historical incidents which caused her concern and said today Ms X had ignored dental advice to have Mr Y's tooth removed, causing Mr Y pain.

30. The Safeguarding Council's case notes say it told the manager that the care home had a duty to ensure Ms X was meeting Mr Y's care needs when visiting her home. If the home felt Mr Y was at risk of harm it could refuse to discharge its care duties to Ms X, for the home visits, until it completed a risk assessment. The notes also say the Safeguarding Council told the manager that if the home decided to do this it would need to put an emergency DoLS in place. This was because restricting home visits would not be covered by the existing DoLS authorisation.

31. The Safeguarding Council then contacted the Council. The Council's case notes say the Safeguarding Council made the following recommendations:

- The Council and care home carry out a risk assessment in conjunction with Ms X.
- The Council should make an application for an emergency DoLS to *"prevent Mr Y seeing Ms X until the risk assessments are in place"*.
- Ensure there is a clear rationale for any decisions preventing Mr Y having contact with Ms X.

32. The Council then spoke to the care home manager. The manager said she was meeting with her area manager to begin the risk assessment tomorrow. The manager also said she would apply for the emergency DoLS. The Council said any restriction to Ms X's contact with Mr Y needed to be the least restrictive option.

33. On 17 July 2016 the manager emailed Ms X to tell her about the safeguarding referral. The manager explained as there were no risk assessments in place for Mr Y's home visits they needed to complete them before any other visits took place. The manager offered to meet with Ms X that week to discuss the matter further. Ms X contacted the Council on 18 July 2016 to challenge the manager's decision.

34. On 21 July 2016 the Safeguarding Council spoke to the care home. It said Mr Y's father may not be a suitable representative for the DoLS as he was not objective. It also repeated that if the home felt Mr Y was at risk from home visits then *"visits to mum should be stopped"* and a risk assessment carried out. The Safeguarding Council also said the home should seek to preserve Mr Y's contact with Ms X through supervised visits.

35. On the same day Ms X asked the Council to review Mr Y's DoLS authorisation. She also asked the home why Mr Y could not visit her. The manager said she was following instructions from the Safeguarding Council. The next day Ms X contacted the Council asking it to take action to prevent the home restricting her access to Mr Y. The Council responded saying it was sorry the Safeguarding Council had decided to restrict access and it would contact the Safeguarding Council to discuss the legal basis for the restriction. Ms X had a supervised visit with Mr Y on 25 July 2016.

36. On 26 July 2016 the Council agreed to review Mr Y's DoLS authorisation and ask the assessor who was best placed to be Mr Y's representative. The Council decided an independent best interests assessor should carry out the review. The care home manager completed a DoLS 10 form to alter the conditions attached to Mr Y's current authorisation. On the form the manager gave details of her concerns about Ms X's behaviour and history of mental health problems.

37. On the same day the manager also told the Council that supervised contact between Ms X and Mr Y was in place and was working well. The Council agreed to find an advocate for Mr Y following a recommendation from the Safeguarding Council.

38. On 28 July 2016 the Council wrote to Ms X explaining the Safeguarding Council had to look into the safeguarding concerns and *"make temporary and appropriate arrangements during this period".* On 1 August 2016 Ms X spoke to the Safeguarding Council. She said she wanted other people to supervise her contact

with Mr Y as this was the least restrictive option. The Safeguarding Council said it would need the names of who Ms X was proposing.

39. The following day the Safeguarding Council spoke to the care home, the Council and Ms X to gather information about the safeguarding referral. Following this the Safeguarding Council decided to take no further action. It told the care home the issue of Ms X's contact with Mr Y needed to be resolved between Ms X, the home and the Council. It also recommended each party come together to establish a better working relationship.

40. The Council agreed Ms X's unsupervised contact with Mr Y should resume but it should still ensure that Mr Y was safe in Ms X's care. It also confirmed the DoLS review should continue to decide who was best place to be Mr Y's representative.

41. On 2 August 2016 Ms X contacted the Council. She asked who had taken the decision to restrict her access to Mr Y and on what legal basis. The Council responded on 5 August 2016. It explained the difference between the DoLS process and safeguarding. It said the Council had not placed restrictions on access between Mr Y and Ms X and not made any temporary changes to Ms X's contact with Mr Y. The Council said it believed the Safeguarding Council requested measures to reduce the risks following safeguarding concerns. Any decision on temporary suspension of contact remained the Safeguarding Councils.

42. As Ms X remained unhappy the Council said it would investigate the issues as a formal complaint. The Council spoke to Mr Y's social worker and asked who had decided to restrict Ms X's access to Mr Y. The social worker said the Safeguarding Council had strongly advised an emergency DoLS authorisation to completely restrict Ms X's access to Mr Y. The social worker said this had seemed excessive and supervised access was more suitable.

43. The Council responded to Ms X on 9 September 2016. It said the Safeguarding Council made clear recommendations to the care home and the Council to prevent Mr Y from seeing Ms X until suitable risk assessments were in place. The Council said the Safeguarding Council must consider the least restrictive option for contact and had recommended a complete restriction under an emergency DoLS. The Council did not see the need for an emergency DoLS as an existing authorisation was in place and decided on supervised access. Its social worker and the care home manager had acted on the instructions of the Safeguarding Council and not made any decision to restrict contact.

44. During this time Mr Y needed more dental treatment and Ms X was on holiday. Ms X discussed the best course of action for the treatment with the care home manager. Ms X disagreed with Mr Y's treatment, she said she had spoken to the dentist and his account of events didn't match the care home managers. The Council said it would look into the matter.

45. On 14 September 2016 the Council completed its DoLS review. It recommended Mr Y have an independent representative. It also recommended mediation between the care home manager and Ms X. It confirmed the DoLS process could not be used to alter contact arrangements between Ms X and Mr Y.

46. The Council wrote to Ms X on 16 September 2016 inviting her to a meeting with itself and the care home. It said it had identified anomalies in the accounts of Mr Y's dental treatment and wanted to discuss these along with Mr Y's needs. On 27 September Ms X complained direct to the care home about the manager's conduct.

47. On 29 September 2016 the Council sent copies of the outcome of the DoLS review to Ms X, Mr Y's father, Mr Y and the care home. The Council included the DoLS 10 form with the review, which included the care home manager's view of Ms X's ability to care for Mr Y. The Council logged this as a data breach on 6 October. On the same day Ms X called the Safeguarding Council. She said she had concerns about the care home manager and she did not believe Mr Y was safe in the care home. The Safeguarding Council advised her to speak to the Council and then raise a safeguarding alert if she still felt Mr Y was in danger.

48. Ms X called the Council on 7 October. She said she was concerned the Council had not questioned the accuracy of the information on the DoLS 10 form. The Council said it would address Ms X's concerns through its complaints process. For clarity, the Council also sent Ms X a letter which set out what aspects of Mr Y's care it was responsible for, what the home was responsible for and what the Safeguarding Council was responsible for.

49. Ms X made a subject access request for information on Mr Y's care on 27 October 2016, including seeing his care plan. The Council carried out a mental capacity assessment of Mr Y and decided he did not have the capacity to decide if Ms X could see his care plan.

50. The Council responded to Ms X's complaint on 22 November 2016. It said while the DoLS 10 form contained safeguarding concerns about Ms X, it was not the cause of the safeguarding referral, which the home had already raised. The DoLS 10 was completed following Ms X's request for a review of the DoLS authorisation. The Council said the views expressed on the form did not impact the review, which was based on an independent best interests assessment. The Council said the form could be retracted if Ms X wanted.

51. On the same the day the Council carried out a review of Mr Y's care and support. It said Mr Y's placement was successful and allowed Mr Y to manage in a home environment with minimal 1:1 support. The review did identify that Mr Y was not always getting all the 1:1 support in his plan, with only one member of staff supervising all 4 residents after 8pm. The Council said this needed further discussion but it was satisfied the care home was meeting Mr Y's needs.

52. On 23 November 2016 the care home took Mr Y to hospital after he slipped outside. The hospital identified a possible hairline fracture and applied a cast. Ms X called the Safeguarding Authority to say she had continuing concerns about the care home. She relayed the painkiller incident from July. The Safeguarding Council said there were no issues of substance for it to investigate at this stage. Ms X said she would wait for the outcome of the care provider's investigation.

53. In December the Council decided it was not in Mr Y's best interests for Ms X to have copies of his care records, as the data belonged to Mr Y. It said it would allow Ms X access to redacted versions of documents that referred to her. This decision was later overturned and the Council gave Ms X access to redacted copies of Mr Y's records.

54. The care provider responded to Ms X's complaint about its manager on 12 December 2016. It agreed the wording used in the DoLS 10 form was unacceptable and unprofessional. The care provider apologised and said it would also send the apology to anyone else who had sight of the form.

55. The provider said in restricting Mr Y's contact with Ms X the manager was acting on advice from the Safeguarding Council. It said the manager had discussed the issue of supervised contact with the Council social worker. The provider said it

had also investigated the manager's care of Mr Y and decisions she had taken in Mr Y's best interests. There was no evidence to show the manager had given Mr Y incorrect medication, or acted against any medical and dental advice. The provider said the manager had acted appropriately in raising safeguarding concerns.

56. The Council sent Ms X a further complaint response on 21 December 2016. It repeated its position the DoLS had not impacted on the safeguarding referral or the DoLS review. It accepted its communication with Ms X had been poor and apologised. It confirmed the DoLS 10 would be withdrawn.

57. On 6 February 2017, following a request from Ms X, the Council carried out a review of the care provider's response to Ms X. It said it was satisfied with the care provider's scrutiny of the complaint and it had addressed each point in full. It was also satisfied that Mr Y had suitable care in place and the issues were now personal ones between the manager and Ms X. The Council recommended a meeting between the two but said there was little more it could do.

58. Ms X disputed the Council's reply and raised the issue of Mr Y's 1:1 support. The Council clarified the issue with the care home and told Ms X it was satisfied this support was in place and the home was meeting Mr Y's needs. It referred Ms X to the Ombudsman.

59. Following this Ms X made a safeguarding referral to the Safeguarding Council about the care home manager. Ms X raised several issues but the Safeguarding Council said most of them were not safeguarding concerns. Following a strategy meeting the Safeguarding Council investigated Ms X's allegation the care home manager had overdosed Mr Y in July 2016. Following the investigation, in June 2017, the safeguarding council decided the claims were not substantiated.

60. After reviewing Mr Y's care records, Ms X complained to the Council the care home manager had made several false claims about Mr Y's care. She said the manager's decision making was biased due to Ms X's history of mental health issues. She repeated her complaint the safeguarding allegations made by the manager against her were false.

61. The Council decided to bring forward Mr Y's care review to confirm his placement at the care home remained suitable. It said any safeguarding complaints had to go to the Safeguarding Council but it would investigate the other claims. The Council wrote to Ms X in July 2017 apologising that its records did not make it clear what was opinion and what was fact. It said it would ensure the Council's guidance on this was better applied in future. Ms X remained unhappy and complained to the Ombudsman.

62. Ms X also contacted the Safeguarding Council on 20 July 2017. She said Mr Y was growing increasingly anxious and she was concerned for his safety. The Safeguarding Council spoke to the Council. It said Mr Y did not appear anxious but it was in the process of carrying out occupational therapy and psychological assessments of Mr Y to decide any changes needed in his care. The Safeguarding Council decided no further action was necessary. Ms X continued to contact the Council and said she had evidence her son was at risk.

63. A best interests meeting was held, following the occupational therapy and psychological assessments of Mr Y. It decided to continue a behavioural assessment of Mr Y over time, while staff should attend sensory awareness training. Ms X contacted the Safeguarding Council again in August saying she had evidence which proved the manager was a risk to Mr Y.

64. In September 2017 the Council completed Mr Y's DoLS assessment. It agreed with the findings of the DoLS review, that Mr Y's placement was a positive one, although Ms X disagreed. The Council took a best interests decision for Mr Y to remain at the home and awarded the maximum DoLS period of 12 months. An independent representative was appointed on 18 September 2017. In November 2017 the Council reviewed Mr Y's care and decided the placement continued to meet his needs.

My findings

Complaint 1: Safeguarding alert against Ms X

65. There is conflicting information over who decided to restrict Ms X's contact with Mr Y. The Safeguarding Council's case notes say the care home could decide to restrict contact, pending a risk assessment, **if** it believed Ms X could not meet Mr Y's care needs. It goes on to say **if** the care home decided to do this it would need to apply for an emergency DoLS as the standard authorisation would not cover any restriction of contact.

66. Evidence from the care home and the Council shows they believed the Safeguarding Council had recommended an emergency DoLS to completely restrict Ms X's access to Mr Y. However, the Council's case notes also say the Safeguarding Council recommended a risk assessment.

67. There is no evidence to support the Council's view the Safeguarding Council directed it and the care home to carry out an emergency DoLS to restrict Ms X's access to Mr Y completely. The Safeguarding Council did discuss the choices open to the care home and the Council but there is no evidence to say it recommended they restrict Ms X's contact with Mr Y. The case notes are clear this was a decision for the Council and the care home, pending a risk assessment.

68. Despite this the care home and the Council were entitled to restrict Ms X's contact with Mr Y if they believed she could not meet his care needs. Any decision to do this would need to be supported with a clear rationale. While the care home manager and the Council discussed the choice of restricted contact, the care home put this in place without the Council's knowledge, only telling the Council once it was in place.

69. The Council and the care home believed they were acting on advice from the Safeguarding Council. Because of this there is no clear reasoning for the decision and no risk assessment. The Council is responsible for the actions of the care home, as it commissioned the care home to care for Mr Y on its behalf. While it is entitled to put restricted contact in place, it is at fault for the confused decision making that led to the decision and the lack of analysis and risk assessment.

70. Ms X's contact with Mr Y was restricted to supervised visits from 15 July 2016 to 2 August 2016. Given the frequency of Mr Y's visits to Ms X this has not caused Ms X a significant personal injustice.

71. Ms X believes the Council deliberately misinformed her about who decided to restrict the contact with Mr Y. I have reviewed case notes from both the Council and the Safeguarding Council and there is no evidence to support this. The information the Council gave Ms X appears to come from genuine miscommunication between the Safeguarding Council, the Council and the care home.

Complaint 2: The care home's investigation

72. The care home carried out an investigation into Ms X's concerns about its manager. This was carried out by a senior manager and reviewed by the Council. The investigation accepts the wording its manager used in the DoLS 10 was inappropriate. The care provider took steps to ensure this did not happen again and withdrew the DoLS 10. I have reviewed the information both the care home and the Council considered and there is no evidence the investigation was flawed. The Council is not at fault.

Complaint 3: Mr Y's care

73. Ms X says she has evidence the care home manager is failing in her duty of care towards Mr Y. The Ombudsman does not reinvestigate safeguarding referrals but considers whether the Council conducted a suitable investigation in line with its safeguarding procedures and relevant guidance. It is the Safeguarding Council who is responsible for investigating any risk to Mr Y.

74. So far the Safeguarding Council has considered information presented by Ms X and decided what action to take. This complaint is not about the Safeguarding Council and I have not investigated its actions. If Ms X is unhappy with the Safeguarding Council it is open to her to complain to the Safeguarding Council and then the Ombudsman if she remains unhappy.

75. The Council is responsible for Mr Y's care needs. It carried out a review of Mr Y's care in November 2017 and said the care home continued to meet his needs. As well as this Mr Y has had occupational therapy, psychological and behavioural assessments recently. No professional involved with Mr Y, including his representative, has raised any concerns about his care. There is no evidence the care home is failing in its duty of care towards Mr Y. The Council is not at fault.

Complaint 4: The Council's notes about Ms X

76. Care notes inevitably contain the views of professionals involved in the case. The Council has guidance in place for its staff on distinguishing between what is fact and what is opinion. In July 2017 the Council wrote to Ms X and accepted certain case notes did not make it clear they were expressing an opinion, or give reasons that opinion. The Council apologised and said it would reiterate its guidance to those concerned.

77. I am satisfied the Council's policy on this issue is suitable, and with the actions the Council took in response to Ms X raising the matter. The Council has taken appropriate steps and there is little outstanding injustice to Ms X. There is nothing more the Ombudsman can achieve.

Agreed action

78. The Council has agreed, within one month, to ensure a risk assessment is in place for Mr Y's visits to Ms X.

79. Within three months the Council agrees to review its procedures for changes to contact arrangements where the person has no capacity. This is to ensure there is a robust documented decision making process in place, that reduces the likelihood of any miscommunication, and makes it clear why the decision is being made and who is taking the decision.

Final decision

80. I have completed my investigation as there is no evidence the fault by the Council has led to a significant injustice to Ms X.

Parts of the complaint that I did not investigate

81. I did not investigate the actions of the Safeguarding Council. If Ms X is unhappy with the Safeguarding Council she will need to raise a separate complaint after completing its complaints process.

Investigator's decision on behalf of the Ombudsman

23 March 2018

Complaint reference:
17 002 241

Complaint against:
Nottinghamshire County Council

Local Government OMBUDSMAN

The Ombudsman's final decision

Summary: Mr and Mrs G complained the Council provided insufficient support in helping Mrs G care for her grandson, 'Child X'. The Ombudsman found fault as the Council did not recognise Child X was a 'looked after child' from the time he entered Mrs G's care. This caused injustice as Mrs G did not receive all the financial or other support the Council should have provided her. The Council has agreed a series of recommendations which aim to remedy this injustice. It will make various back-payments to Mrs G and review the support it currently offers her.

The complaint

1. The complainants, whom I have called "Mr and Mrs G" complained about the extent of support they received from the Council after Mrs G agreed to care for their grandson, whom I have called "Child X". Since the end of July 2015 Child X has lived with Mrs G. Mr and Mrs G complained the Council:

a) Would not recognise that Child X entered Mrs G's care as a looked after child given concerns the Council had for his welfare.

b) That as a result Mrs G did not receive enough financial support for Child X between July 2015 and November 2016; at which point she obtained a Special Guardianship Order (SGO) for him.

c) That further, because the Council did not consider Child X a looked after child, it had also provided inadequate support for Mrs G after November 2016, under the Special Guardianship Regulations.

What I have investigated

2. I considered most of Mr and Mrs G's complaint to be within the Ombudsman's jurisdiction to investigate. However, I did not consider I could investigate the support provided by the Council to Mrs G between 21 November 2016 and 19 January 2017. I explain my reasons at the end of this decision statement.

The Ombudsman's role and powers

3. We cannot investigate late complaints unless we decide there are good reasons. Late complaints are when someone takes more than 12 months to complain to us about something a council has done. ***(Local Government Act 1974, sections 26B and 34D, as amended)***

4. We cannot investigate a complaint about the start of court action or what happened in court. ***(Local Government Act 1974, Schedule 5/5A, paragraph 1/3, as amended)***

5. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***

6. If we are satisfied with a council's actions or proposed actions, we can complete our investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

7. Under the information sharing agreement between the Local Government and Social Care Ombudsman and the Office for Standards in Education, Children's Services and Skills (Ofsted), we will share this decision with Ofsted.

How I considered this complaint

8. Before completing my investigation and issuing this decision statement I considered the following:

- Mr G's letter of complaint and supporting information provided by him and Mrs G in further correspondence and telephone conversations.
- The Council's replies to Mr G's complaint issued before we began our investigation.
- Information provided by the Council in response to various written enquiries.
- Relevant law and government guidance as referred to in the text below.
- Past decisions and publications by the Local Government Ombudsman of relevance to this investigation. In particular, a report issued against Liverpool City Council (reference 12 006 209) and a special focus report "*Family Values: Council services to family and friends who care for others' children*" published in November 2013.

9. I also sent both Mr and Mrs G and the Council a draft decision statement setting out my provisional thinking about the complaint. I considered comments made in response and amended the final wording of this decision statement accordingly.

10. Under the information sharing agreement between the Local Government and Social Care Ombudsman and the Office for Standards in Education, Children's Services and Skills (Ofsted), we will share this decision with Ofsted.

What I found

The Ombudsman's jurisdiction

11. Before turning to the specific events covered by Mr and Mrs G's complaint I needed to consider the extent to which the Ombudsman could investigate it. This was because of the jurisdictional issues set out in paragraphs 3 and 4 above.

12. I decided that to conduct an effective investigation into the complaint we had to consider events from around May 2015, three months before Child X went to live with Mrs G. I considered we had to examine the circumstances where Child X entered Mrs G's care. Otherwise we could not form a view on what support the Council should have provided to Mrs G after she became Child X's Special

Guardian. The Special Guardianship Regulations provide for different support in cases where a child enters a Special Guardian's care as a 'looked after child'.

13. Second, I considered the impact of the Court proceedings which made Mrs G Special Guardian for Child X. I decided these did not prevent investigation of most of this complaint. The primary purpose of the Court hearing in November 2016 was to decide whether to make Mrs G a Special Guardian or not. But I could not ignore the order also referred to a letter given by the Council to Mrs G on 21 November 2016.

14. The letter assured Mrs G of certain support the Council would provide once the Court made Child X the subject of a SGO. This included specific commitments on financial support until 19 January 2017 at which point the support would drop to a lower level.

15. I considered we could not investigate any complaint about the content of the 21 November letter for reasons explained at the end of this statement. However, I did not consider the letter set in stone the support the Council would offer Child X beyond 19 January 2017. Because it left open the question of both financial and non-financial support for Child X after 19 January 2017. We could therefore investigate a complaint about the support given to Mrs G both before 21 November 2016 and after 19 January 2017.

Legal Considerations

16. Every Council with responsibility for children's services must provide accommodation for children within their area who need it. Circumstances where the Council has this duty include where no-one has parental responsibility for a child and for lost or abandoned children. It also includes circumstances where a person who has cared for a child can no longer provide them with "*suitable accommodation or care*" (Section 20 of the Children's Act 1989). A child cared for by the Council in these circumstances becomes a 'looked after child'.

17. A Council can fulfil its duty to accommodate looked after children through placing them with family. The family member receiving the child then becomes a 'family and friends foster carer'. Being a family and friends foster carer entitles the family carer to weekly fostering payments and social work support. Any payments should be at the same rate as paid to local authority foster carers. There is no equivalent financial support for parents who arrange informally for their children to live with relatives. They are not 'looked after' children as defined above.

18. However, a Council with responsibility for children's services must also provide services for 'children in need'. The Children's Act defines these as children who need services from the Council *"to maintain a reasonable standard of health and development or to prevent harm".* Children who live with family and friends under informal arrangements can receive financial support therefore as 'children in need'.

19. Any fostering allowances paid in line with the advice in paragraph 16 should include any extra allowances the foster carer would have a right to. For example, if the Council pays an increased fostering rate to children with disabilities then a family and friends foster carer should receive that allowance if caring for a child so entitled. Councils should pay all fostering allowances at least at the minimum rate set out by government.

20. There can be dispute (as in this case) about whether a child is a 'looked after child' or has moved to a relative under an informal arrangement. In 2007 a Court

judgment against the London Borough of Southwark provided guidance on how to decide this question. The Court held:

- That if the Council played *"a major role"* in arranging for the child's move then the most likely conclusion was that it exercised its powers and duties to accommodate the child.
- That an informal arrangement will usually be one directly between the parents and relative with no Council involvement.
- That if the Council was simply facilitating an informal family care arrangement then it must be clear with those involved about its involvement. This would include giving clear advice to the relative caring for the child about who is financially responsible. For example, giving the relative receiving the child advice to *"look to the person with parental responsibility"*.

21. A relative with care of a child can apply for a Special Guardianship Order which gives them parental responsibility over the child. Such an order makes the relative the child's 'special guardian'. If a relative caring for a 'looked after child' becomes a special guardian then the child will no longer be a 'looked after child'.

22. However, a special guardian may remain entitled to support for the child. The local authority responsible for agreeing the special guardianship order has responsibility for providing financial support for the child. It can pay a Special Guardianship Allowance to the Special Guardian. However, this is not automatic as the allowance is means tested. The Courts have held that special guardianship allowances should be in line with fostering allowances.

23. More generally, any support given to Special Guardians must be in line with the Special Guardianship Regulations 2005 (amended in 2016) and Government publishes guidance in support of those. The local authority where the special guardian lives is usually responsible for undertaking any assessment of need for the child, as well as any special guardianship support services in response to that assessment. But there is one exception. That is where a child was a 'looked after child' before the making of the special guardianship order. In which case, such support remains the responsibility of the authority where the child became looked after. Although where a child lives outside its area that authority can enter an arrangement with another authority to discharge its responsibilities.

Did Child X enter Mrs G's care as a 'looked after child'?

24. At the beginning of events covered by this complaint (May 2015) Child X lived in the Council's area in the care of his mother who I will call 'Ms Y'. Mrs G is Child X's parental grandmother. She is married to Mr G but they maintain separate houses, with Mr G living in another area again around 200 miles from Mrs G.

25. Child X has several siblings. In May 2015, all were subject to Child Protection Plans. As a result, the Council children's' services had frequent involvement with the family. Ms Y was pregnant and expecting another baby in August 2015.

26. Child X went to live with Mrs G in late July 2015. The Council said this followed an informal family arrangement or private fostering arrangement agreed between her and Ms Y. It said that it did not play a 'major role' in arranging for Child X to live with Mrs G. So, it did not need to give advice to Mrs G of the kind envisaged in the Southwark judgment.

27. Mr and Mrs G said this was incorrect. Mrs G agreed to care for Child X because she understood the alternative would be that he entered local authority care. Mr

and Mrs G argue that in effect, Child X, became therefore a 'looked after child' when he entered Mrs G's care.

28. I found the weight of evidence in this case supported Mr and Mrs G's case more than that of the Council. I noted the Council drew attention to contemporaneous references in some of Child X's case notes that referred to his move being an *"informal family arrangement"*. But simply saying this did not make it so. Having read hundreds of pages of case notes in this case I found the following picture emerged which demonstrated the Council had a 'major role' in his move to Mrs G's care.

29. First, it became clear from May 2015 onwards the Council began recording increasing concern about Child X's behaviour. It recorded him becoming *"increasingly violent when he feels unable to cope".* It recorded him throwing and breaking items in the home. Also, it recorded his exclusion from school for assaulting staff and damaging a classroom. The Council recorded that at the time there were no plans to consider taking Child X or any of his siblings into care. But it also recorded the case needed regular review.

30. So, throughout May and June there were regular visits to Child X's home by a family support worker and social workers. They reported continuing concerns with Child X's behaviours at home and in school. A Child Protection Conference held on 13 July 2015 held the worries about the family justified increasing visits to daily from now on. On the following day, a Council worker found faeces smeared around the family home, which Ms Y attributed to Child X.

31. It appears this was the trigger point for the second phase of the Council's involvement when it began actively considering if Child X should move out of the family home. It social worker recorded an internal discussion on 14 July 2015 saying: "*we discussed [Child X] having behavioural problems and mother is unable to deal with this – discussed whether it would be worth considering [he] be accommodated for a short period of time [..] [Ms Y] was reluctant to do this but agreed as she was concerned that [Child X] would be placed in care. I had been reinforcing with [Ms Y] the concerns that had been raised about [Child X] assaulting the new born baby"*

32. I found a first mention of Mrs G in the case papers around this time. The Council recorded her speaking to its social worker on 16 July 2015. The social worker recorded Mrs G being willing to look after Ms Y's children *"to prevent them going into care"*.

33. On 20 July 2015, the Council reported Child X assaulting Ms Y. A Family Resource Worker for the Council recorded telling Ms Y of her concerns should Child X remain in her care, along the lines set out at paragraph 31.

34. Third, the Council next encouraged a move for Child X to live with Mrs G. On 21 July 2015, a social work manager said the Council provisionally supported Child X going to live with Mrs G. They advised Child X's social worker to arrange background checks on Mr and Mrs G and to visit Mrs G's home. Another note of a contact with Ms Y dated 21 July 2015 recorded her saying Child X was *"having to leave"* her care.

35. On 22 July 2015, a further child protection conference review took place. The minutes recorded Child X's social worker saying she was "*very concerned*" about Child X's behaviours. Further it records her saying: "*her manager had indicated [Child X] should be placed in local authority care because of the behaviours he displays and the risk to the unborn child"*. The minutes recorded Ms Y becoming

upset as *"she did not want [Child X] to go into care"*. The minutes then record Mrs G offering to care for Child X *"for a short time"*. Ms Y then asks the social worker *"how long"* the placement would be for and the social worker's response is that she *"was not able to say".*

36. If there was any doubt about the accuracy of this minute I consider this dispelled by the later statements of Mrs G and Ms Y. From 7 August 2015 onwards I found many statements on the Council's files of Mrs G's understanding of events. She has repeatedly said she agreed to look after Child X as an alternative to the Council beginning care proceedings. She understood the Council was on the brink of taking such proceedings on 22 July.

37. The case papers also contain references to Ms Y's understanding of events. She has repeatedly said that if she had not agreed to Child X moving to Mrs G's home the Council would have taken him into care.

38. I found the Council's involvement in the case entered a fourth phase after 22 July 2015. It then began to consolidate Child X's move into Mrs G's care. There are references to the Council asking Ms Y to sign agreements under Section20 of the Children's Act to consent to all her children being put in local authority care. I understand mostly this was a purely short-term measure while she entered hospital to give birth. But there is a note on 6 August the Council wanted Ms Y to sign "*a written agreement […] to say she now agrees [Child X] to remain with [Mrs G] long term"*. The Council recorded its social worker asking Ms Y to sign such an agreement on11 August but she was not at home when they called.

39. The case records therefore documented the evolving and increasing involvement of the Council in Child X's case between May and August 2015. I considered the facts set out above showed the Council had a *"major role"* in arranging for Child X to live with Mrs G. I am satisfied it actively encouraged and then consolidated his move. Even if the Council did not get to the position where it weighed up the likely success of taking Court proceedings for Child X to enter local authority care this was clearly something under consideration.

40. It was also not prepared to let Child X live anywhere. That it undertook background checks of Mr and Mrs G and Mrs G's home show that it was concerned to place Child X in a safer environment. Further it is not the case the Council ever told Mrs G to *"look to the person with parental responsibility"* for financial support for Child X (i.e. Ms Y). On the contrary, in a case conference on 29 July 2015 the Council recorded the need to make financial support available to Mrs G. It then went on to support Mrs G financially in her care of Child X.

41. I considered the Council at fault therefore for not considering Child X a 'looked after child' from July 2015 onward. The injustice this caused is as follows. First there were practical consequences for the support offered to Mrs G which I discuss below. Second the Council's actions also caused distress to both Mrs G and her husband, as it consistently failed to recognise the sequence of events which led to Child X entering Mrs G's care. This in turn led also to Mr and Mrs G experiencing unnecessary time and trouble; both in trying to secure the services to support the care of Child X which Mrs G should have received from the outset and in pursuing complaint about this matter.

Was the scope of the Council's support to Child X sufficient pre-November 2016?

42. Soon after Child X entered Mrs G's care the Council began providing her with financial support. This was at a rate of around £114 a week. The Council says it

calculated this amount as equivalent to state benefits which Mrs G might receive for Child X. It says it paid Mrs G under Section 17 of the Children's Act as it considered Child X a "child in need".

43. It follows from my finding above that I did not consider these payments were enough. If Child X was a 'looked after child' and the evidence supports that he was, then it followed that Mrs G should have received fostering allowances for him. The Council was at fault for not paying those allowances.

44. So, there was a shortfall in the financial support Mrs G received from the Council in caring for Child X. The national fostering allowance for the 2015/16 financial year was £139 a week for a child of Child X's age, rising to £141 from April 2016. Mrs G therefore did not receive an amount equivalent to the difference between these amounts and the £114 a week paid by the Council. This was an injustice.

45. Beyond this I also note that before Mrs G became Child X's special guardian he remained subject to a Child in Need plan. Part of that plan required Mrs G to continue to encourage and promote contact for Child X with his birth parents. As I noted above, Mrs G does not live in the Council's area. She lives around 65 miles away from Child X's parents who live within that area. So, each contact visit made after August 2015 has involved a round trip of around 130 miles. Mrs G reports neither of Child X's birth parents willing or possibly able to travel to Mrs G or support with the costs of these trips. Further Mrs G has consistently stated to the Council that Child X's needs mean he becomes anxious and his behaviour disruptive on public transport (the minutes of Child in Need reviews for February and April 2016 refer for example). Given that Mrs G does not have her own transport this meant she paid for a taxi to make the round trip instead of using public transport.

46. Under whatever provision the Council financially supported Mrs G before she became Child X's special guardian, I consider it should have been giving more attention to this cost of promoting contact. I noted that from April 2016 Mrs G reported she could not financially maintain the visits to Child X's parents, yet there is no suggestion the Council reconsidered the amount of support it provided. I considered that was inattention and justified a further finding of fault.

47. This fault also created its own separate injustice. Because I am doubtful that even if Mrs G had received the national fostering allowance from the moment Child X entered her care, this could have met the need to also promote contact.

48. I noted Government guidance also refers to children with extra needs. It says that if a council pays an extra allowance to meet those needs, then it should also pay that allowance to the family and friends foster carer.

49. The Council has clarified it did not (and does not) have a policy to pay foster carers extra allowances if caring for children with extra needs. Instead it pays certain carers a premium based on their experience and expertise. So, I cannot find the Council should also have paid Mrs G a further allowance to reflect Child X's extra needs.

50. But the Council does still make some payments above the basic minimum fostering allowances. Its policy since April 2016, explained on its website has been to make some added payments as follows:

- To pay a fostering supplement of £10 a week per child as well as the national minimum fostering allowances.

- To pay birthday and festivities allowances. I note Child X had a birthday in 2016 before Mrs G became his special guardian.
- To pay a holiday allowance.

51. I saw no reason why Mrs G could not receive payments for Child X in line with the policy summarised at paragraph 50. There has been a further injustice therefore in Mrs G not receiving these payments.

Has the support provided to Mrs G after 21 January 2017 been sufficient?

52. In this case, as I have explained, the Council treated Child X as a 'child in need' from the time he entered Mrs G's care. Until the SGO was made it therefore maintained a support plan for his care, subject to regular review. But once Child X became subject of the SGO the Council sought to end this involvement.

53. It flows from the findings I have made above that there was fault in this approach. I do not consider the Council could close Child X's case just because he was now subject of a SGO. If Mrs G needed support services after the SGO was made then the Council had to consider what support services she needed and to arrange those.

54. I noted that in the Child in Need reviews Mrs G had challenged the Council's proposal to end its involvement. In response, the Council suggested there would be little role for its services in any event. This is because its records suggested Mrs G had engaged with local services including enrolling Child X in a local school and with GP services who referred him to Child and Adolescent Mental Health (CAMHS) services. The minutes of the reviews also detailed efforts made by Child X's school aimed at helping him with coping strategies. However, I did not think the Council could fetter its discretion not to consider if Mrs G might need further support. For example, exploring the possibility of respite or additional support to meet Child X's needs out of school hours.

55. During this investigation, in September 2017, Child X received an assessment of need from a third-party organisation which provides a useful snapshot of his current needs. I understand this followed contact between Mr and Mrs G and the Children's Commissioner. The assessment, sent to Mrs G's home authority, says Child X has a diagnosis of autism, a learning disability, mental health issues, attention deficit hyperactivity disorder (ADHD) and an attachment disorder. These contribute to severe behavioural issues of the kind described with episodes of self-harming, smearing, violent outbursts of temper towards people and property and so on.

56. I am satisfied from the statements made to me by Mr and Mrs G that caring for a child with these multiple and complex needs has been difficult for Mrs G. The assessment in September 2017 again provides a snapshot of the pressure she feels under, for example in maintaining her employment. I find this also reflected in the Child in Need minutes when the Council maintained its management of the case and in statements made in the complaint. I cannot say for sure what further social care support the Council should provide or should have provided Mrs G in the absence of an up to date needs assessment. But I consider it likely Mrs G would have an entitlement to some additional support. A further injustice she has suffered therefore is distress in the form of uncertainty; not knowing if the Council could do more to offer services to support her.

57. In support of this finding, I note Child X is currently being assessed further by Mrs G's home authority further to the third-party assessment I referred to above. I also understand a referral for Child X to have an Education, Health and Care Plan

(EHCP) has been undertaken. I took account of these developments in making recommendations for action I wanted the Council to take to remedy this injustice, which it has agreed and which are detailed below.

58. I turn next to the financial support provided by the Council. The allowance it currently pays Mrs G follows the model published by the Government which says Special Guardianship allowances can be means tested. The start point is to use the basic minimum allowance paid to foster carers. But unlike foster carers, a Special Guardian can claim state benefits for their child and so these (along with other income) are considered when deciding on a weekly allowance. The assessment also takes account of the Special Guardian's outgoings.

59. I considered the Council's most recent assessment of the allowance paid to Mrs G which decided she could receive around £55 a week in support. While I could see no arithmetical error in the means assessment I considered the Council was at fault for potentially not including certain matters within its assessment that it could consider.

60. First, the model suggests that money used to pay loans for needs incurred by the Special Guardian resulting from becoming the Special Guardian might be included in the assessment. Mrs G declared loans on the assessment which I understand were used to buy an extra bed-settee and furniture essential for her to accommodate Child X. But the assessor asked no information about these loans and so did not consider including the payments in the assessment.

61. Second, the model says an authority can include "reasonable" child care costs in the expenses incurred by the Special Guardian. Mrs G declared child care costs on her assessment but no enquiries were made about these and they were not included in the assessment.

62. I considered the Council at fault for the oversights set out in paragraphs 60 and 61. I could not say the assessment was necessarily flawed because I did not know if the Council should have included these amounts in its assessment of Mrs G's expenses. But I considered the point arguable. So, there was further distress in the form of uncertainty and therefore an injustice.

63. I also considered there was another potential oversight. In paragraphs 44 and 45 I referred to the expectation, which the Council has always maintained, that Mrs G should maintain contact for Child X with his birth parents. I have set out above my concern the money Mrs G received before November 2016 was not enough to facilitate this.

64. Since January 2016 the Council has paid around £44 a month as a "contribution" to the costs of facilitating that contact. It follows from my earlier findings, that my concern extends to this arrangement also. This is because of Child X's needs and the comments made by Mrs G about the difficulties he encounters with public transport as a result.

65. In comments made during this investigation the Council indicated a willingness to reconsider here. It said it was committed to *"the principle it will fund two contact visits a month".* Although it also said it had *"nothing in our knowledge"* to suggest Child X cannot use public transport.

66. I do not agree with the Council's view as Mrs G's statements on the matter must amount to some evidence of the difficulties she faces. However, I accepted the Council might want more assessment or expert opinion to inform what it should reasonably fund when it comes to Mrs G transporting Child X.

67. Further complicating matters I understand that over time Child X's contact arrangements have changed. So, while Mrs G has arranged multiple visits for him to his birth parents these have not necessarily followed the pattern of one to each parent each month. Mr and Mrs G advise for example that in recent months Child X has wanted less contact with Mrs Y.

68. I considered it was further inattention for the Council not to have reviewed the support given to Mrs G with funding contact after January 2016. That was a fault. This caused further injustice to Mrs G in the form of uncertainty. As while I have insufficient evidence to reach a judgment on what the Council should have reasonably funded to support contact, that uncertainty is again a cause of distress.

Agreed action

69. At paragraphs 41, 44, 47, 51, 56, 62 and 68 I have identified where I considered fault by the Council caused injustice to Mrs G and/or Mr G and/or (by implication) Child X. The Council has accepted this finding and has agreed to undertake a series of actions to remedy the resulting injustice. First, within 20 working days of this decision statement it will:

a) Provide an unreserved apology to Mr and Mrs G accepting the findings of this investigation.

b) Pay £1000 to Mrs G in recognition of the distress identified at paragraphs 40 and 55 of this draft.

c) Pay £300 to Mr & Mrs G in recognition of the unnecessary time and trouble they have been put to, which I identified at paragraph 40 of this draft.

d) Pay the shortfall between the payments Mrs G received between 1 August 2015 and November 2016 as Section 17 payments and what she should have been paid as fostering allowances, as identified in paragraph 43 of the draft. The Council should provide an explanation for how it calculates the sum owing which I estimate will be around £1700.

e) Pay any allowances to which Mrs G would also have been entitled as a foster carer before November 2016 as identified in paragraph 50 of the draft. The Council should provide an explanation for how it calculates the sum owing.

70. Second, to further remedy the injustice identified at paragraph 56 the Council will contact Mrs G's home authority within 20 working days of a decision on this complaint to discuss Child X and Mrs G's care needs moving forward. The Council will enquire what support that authority is currently providing and/or what assessments it is undertaking. It will agree to take over the financing of any care needs currently being met by that authority and/or agree with that authority how Mrs G's support needs moving forward will be assessed, maintained and reviewed. The Council will agree to maintain whatever support Mrs G needs in line with Special Guardianship Regulations until November 2019. It can delegate certain tasks by agreement with Mrs G's home authority in line with the Regulations.

71. Third, within three months of a decision on this complaint I want the Council to complete a re-assessment of the financial support it currently pays to Mrs G. To complete this part of the remedy the Council will need Mr and Mrs G's co-operation to meet with its officers and provide any financial records reasonably required. The re-assesment will:

a) Include a fresh means assessment of the SGO payments Mrs G currently receives. This will take account of the potential oversights identified in paragraphs 60 and 61 of this decision and resulting injustice at paragraph 62. Any increase in the weekly payment given to Mrs G will be backdated to 6 March 2017 (the date of the previous assessment).

b) To address the injustice identified in paragraphs 47 and 68 the Council should re-consider the financial support it has historically provided for Mrs G to support contact visits for Child X and what it should provide moving forward. The Council will meet with Mrs G and establish the following:

   i. What contact has taken place since April 2016 between Child X and his birth parents; while Mrs G may not have a complete record, the Council should do its best to establish the number of such visits and any changes in the patterns of the visits over time.

   ii. How that contact has been facilitated; i.e. has it always been a case of Child X visiting his birth parents or have they made any trips to visit him, Have visits been undertaken on public transport or by taxi. What costs has Mrs G incurred in making those visits.

   iii. The reasons why Mrs G says she cannot use public transport for Child X.

72. The meeting referred to at paragraph 71 will take place at a neutral venue and Mrs G will be entitled to bring along support (she has suggested her local Ward Councillor in the area where she lives who has also volunteered to provide a venue from that authoirty's offices). If necessary, before or after that meeting, the Council can request information from third parties such as Child X's birth parents or professionals working with him; to help verify the pattern of visits or comment on the issues Mrs G reports with him using public transport.

73. Once the Council has completed its enquiries it will write to Mrs G and address the following:

a) It will review the payments historically made to support contact from April 2016 (excluding the period 21 November 2016 to 19 January 2017) and consider if those were adequate. It will provide a financial remedy to Mrs G if it no longer considers the sums it provided to her were reasonable and an explanation for how it has calculated any amount paid. It will explain if it maintains the sum provided was reasonable.

b) It will consider the situation moving forward and whether it still considers it necessary for Mrs G to be providing two contact visits a month and the funding that it will provide to support with those visits.

74. Concerning the agreed action at 69d) I have noted that alternate dates appeared in the case papers about the exact date when Child X went to live with Mrs G in July 2015. But they all agreed he had lived with Mrs G from the end of the month at the latest. That is why my agreed action takes effect from 1 August 2015.

75. Concerning the agreed action at 69 e) above I do not know if the allowances referred to in paragraph 49 were also in payment for the 2015-16 financial year. The agreed action will cover at least the period from April 2016 to 20 November 2016. But if it is the case such allowances were also payable in 2015-16 then a backdated award will also be made to cover the period from 1 August 2015 to 31 March 2016 also.

76. Concerning the agreed action set out between paragraphs 71 and 73 if Mrs G is unhappy with the outcome of any further assessment she may contact this office

again. We will consider if the Council has satisfactorily completed the agreed action and undertake any further investigation necessary to come to a view on that.

Final decision

77. We have upheld this complaint finding the Council acted with fault causing injustice to the complainants. The Council has now agreed action we consider will provide a fair remedy for that injustice. Consequently, we have completed our investigation satisfied with its actions.

Parts of the complaint that I did not investigate

78. I did not investigate events between 21 November 2016 and 19 January 2017. This was because the Special Guardianship Order cross-referenced a letter given by the Council to Mrs G which expressly set out what support it would offer her between those dates. The Court therefore considered its contents when considering the making of the Special Guardianship Order and I understood would not make the Order without such assurances from the Council. I understood Mr and Mrs G feel the assurances may not have gone far enough but I considered that as they were considered expressly by the Court we could not re-open any discussion of the support set out in that letter which Mrs G received. So, the service given by the Council to Mrs G between these dates fell outside our jurisdiction.

Investigator's decision on behalf of the Ombudsman

29 March 2018

Complaint reference:
17 012 327

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Mrs X complained on behalf of her mother about the Council's decision that her mother had deprived herself of assets with the intention of avoiding charges for care she received at home. Mrs X also complained about delays in the Council's complaints process. The Ombudsman found the Council was at fault for failing to consider the deprivation of assets issue properly. We also found the Council delayed dealing with Mrs X's complaint. The Council has agreed to carry out a further financial assessment and to apologise for failing to keep Mrs X properly informed about the progress of her complaint.

The complaint

1. Mrs X complained on behalf of her mother, Mrs Y, about the Council's decision to charge her the full cost of her care at home. She also complained that the Council delayed handling her complaint about the issue and failed to update her about the progress of the complaint.

The Ombudsman's role and powers

2. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***

3. If we are satisfied with a council's actions or proposed actions, we can complete our investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

4. I have considered information from:

   - Mrs X's complaint and a telephone conversation with her; and
   - the Council's complaints procedure and its response to my enquiries.

5. I have given Mrs X and the Council the opportunity to comment on a draft of this decision.

What I found

Legal background to charging for care and support services

6. The Council can make charges for care and support services they provide or arrange. When the Council arranges home care support it undertakes a financial assessment to decide how much a person has to pay towards the costs of that care. The Care and Support (Charging and Assessment of Resources) Regulations 2014 say the Council does not have to pay towards the cost of care and support in their homes for people who have over the upper capital limit of £23,250. However, once someone's capital has reduced to less than the upper capital limit, they only have to pay an assessed contribution towards the charges. The Council must assess the means of people who have less than the upper capital limit, to decide how much they can contribute towards the cost of the care fees.

7. Councils should follow the Care and Support Statutory Guidance (the Guidance) when undertaking a financial assessment. The Guidance says a deprivation of assets occurs where a person has intentionally deprived or decreased their overall assets to reduce the amount they are charged for their care.

8. The Guidance says councils should consider the following before deciding whether deprivation for the purpose of avoiding care and support charges has occurred:

   - Whether avoiding the care and support charge was a significant motivation;
   - The timing of the disposal of the asset. At the point the capital was disposed of could the person have a reasonable expectation of the need for care and support?
   - Did the person have a reasonable expectation of needing to contribute to the cost of their eligible care needs?

9. The Guidance says it would be unreasonable to decide that a person had disposed of an asset in order to reduce the charges for their care and support needs if, at the time the disposal took place, they were fit and healthy and could not have foreseen the need for care and support.

10. If the Council decides that a person has deliberately deprived themselves of assets it may charge the person as if they still had the assets.

11. The Guidance says it is up to the person to prove to the Council they no longer have an asset. If they cannot prove it, the Council must assess them as if they still had the asset. Acceptable evidence of disposal of capital assets would be a trust deed, deed of gift, receipts for expenditure and proof that debts have been repaid.

Background

12. Mrs Y has lived in a warden-assisted Council bungalow since 2005. She has a personal alarm to call for help if a warden is not available. In 2006 the Council provided equipment to help with toilet transfers, a shower chair and grab rails. Mrs Y has received the lower rate of Attendance Allowance since 2005 and has used that money to pay for cleaning and gardening.

13. In 2014 Mrs Y went into hospital after a fall. In August 2014 the Council provided some re-ablement care when Mrs Y returned home through its Short Term Assessment and Re-ablement Team (START). The Council's notes record Mrs Y declined a financial assessment as she was hoping not to need any more than re-

ablement services. She had support from START for two weeks and was independent again after that.

14. In March 2015 Mrs Y gave £30,000 of her savings to family members. She says she gave money to two grandchildren to help them after their mother (her daughter) had died. She also gave money to her four daughters for a family holiday.

Events December 2015 – March 2016

15. Mrs X says Mrs Y's health worsened later in 2015. In December 2015 another of Mrs Y's daughter's, Mrs B, rang the Council to ask if Mrs Y could receive three care visits a day at home. The Council's notes of the call record Mrs B told the officer Mrs Y was under the financial threshold. The officer explained the Council would assess Mrs Y's eligibility for care then, if eligible, would carry out a financial assessment.

16. START provided three care visits a day from January 2016 to early March 2016. Mrs Y's health improved during this time. A Council social worker completed an assessment of Mrs Y's care needs in mid February 2016. The officer recorded Mrs Y as 10 years older than she was. The officer recorded Mrs Y had a medical history of osteoporosis, stooped posture, kidney condition, hearing impairment and being breathless on exertion. The officer decided Mrs Y should have a package of care at home. This would prevent Mrs Y having a dip in her health again and, in the long term, prevent hospital admission and discharge to a care home. The officer considered Mrs Y needed two care visits a day and some domestic help. Mrs Y started having her two visits a day on 9 March 2016.

The financial assessment in 2016

17. Mrs Y completed a financial assessment form on 2 March 2016. The Council received it on 8 March.

18. The assessment form asks for details of any savings or capital investments given to other people in the last six years by transfer, gift or being placed in trust. Mrs Y said on 20 March 2015 she had gifted £30,000 to her four daughters and two grandchildren. She provided a copy of her bank statement which showed the transactions. She said when gifting this money the only health problems she had were related to old age. She said she had arthritis and reduced mobility.

19. The Council completed the financial assessment on 29 April 2016. The Council considered that, by gifting £30,000 to family members, Mrs Y had deprived herself of that capital asset to avoid paying care charges. The Council has provided no records of how it reached that decision. The financial assessment showed the Council had included the £30,000 Mrs Y had given to her family as 'notional capital'. This meant the Council treated her as having capital over the financial threshold so she had to pay the full cost of her care.

20. Mrs X spoke to a Council officer about its decision to treat £30,000 as notional capital. The Council did not ask Mrs Y or her family for any further information about the gifting of £30,000.

21. On 8 July 2016 the officer wrote to Mrs X and said she had reviewed the decision. The officer made these points:

- She said "*It is up to the person to prove to the local authority that the capital has been legitimately spent by providing evidence that it has been spent on either of the following – a) a trust deed, b) deed of gift, c) receipts for expenditure, d) proof debts that debts have been repaid. The Care Act states*

that if the person is unable to provide evidence, then the local authority must assess them as if they still have the asset."

- She said the Council could expect residents to consider the possibility of having care needs and to plan how to provide for them. So it was difficult to understand why Mrs Y would gift around two thirds of her savings at this time in her life.
- While it was appreciated that Mrs Y wanted to gift money to her family, this could have been done through seeking financial or legal advice or via a will.
- Having received Attendance Allowance since 2005 showed Mrs Y needed help with her care.

22. After this review Mrs Y paid her full care costs.

The financial reassessment in 2017 and Mrs Y's complaint

23. In April 2017 Mrs Y asked the Council for a financial reassessment. The reassessment still treated the £30,000 as notional capital because of the decision on deprivation of assets. On 11 July 2017 Mrs X submitted a complaint about the decision. She said in March 2015 when Mrs Y gave money to her grandchildren she was still totally independent, seeing to her own care needs and still driving her own car. She said there was no expectation Mrs Y would be in need of support and care in nine months time. She said even after Mrs Y fell in 2014 and was entitled to six weeks of care when leaving hospital she only had two weeks care. Mrs Y was then back to being independent and looking after herself. She asked the Council to say why it decided Mrs Y had deliberately deprived herself.

24. The Council's complaints process says in most cases it will respond to a complaint within 20 working days.

25. The Council investigated Mrs X's complaint. It did not contact Mrs Y or her family for any further evidence. Between July and September the Council told Mrs X of delays dealing with her complaint only when she asked about progress. The Council responded to the complaint on 25 September 2017.

26. The officer responding apologised for the delay. The Council has explained to me the delay was caused by the need to consider the complaint fully and the staff involved being on annual leave. The officer upheld the decision about deprivation of assets. The officer went through the evidence the Council had about Mrs Y's health needs before she gifted the £30,000:

- her receipt of Attendance Allowance which is awarded to people needing help with personal care;
- the equipment provided by the Council in 2006 to help someone with limited mobility;
- Mrs Y's known medical conditions at the time she received re-ablement services in 2014 – hypertension, urine retention, arthritis and back problems which affected her mobility and ability to function;

27. The officer decided at the time Mrs Y gifted the £30,000 she had health needs which led to her needing personal care and support. The officer also repeated what her colleague had said the previous year, "*It is up to the person to prove to the local authority that the capital has been legitimately spent by providing evidence that it has been spent on either of the following – a) a trust deed, b) deed of gift, c) receipts for expenditure, d) proof debts that debts have been*

repaid. The Care Act states that if the person is unable to provide evidence, then the local authority must assess them as if they still have the asset."

28. In response to my enquiries the Council has said Mrs Y was aware of the need to pay for care and support. She had already been paying for some support herself and had had previous contact with Social Services. It said Mrs Y was likely to need care, as shown by her move to warden assisted accommodation with an alarm system, her medical conditions, and her receipt of Attendance Allowance since January 2005.

Findings

Deprivation decision

29. Mrs Y gifted £30,000 to family members and she has never tried to hide it. In coming to its decision about deprivation of assets the Council should have addressed the three key issues set out in the Guidance and set out in paragraph 8 above.

30. The Council did consider two of the issues at paragraph 5. But there is no evidence it considered properly whether, when Mrs Y gifted the £30,000, a significant motivation was an attempt to avoid care and support charges. To consider the issue of motivation properly the Council would have to speak to Mrs Y and maybe other members of the family. The Council would need their views of why Mrs Y gifted the money at that time and what consideration she gave to any potential need for care and support in the future. The Council would also need to be sure it took into account Mrs Y's correct age. The Council did not consider these issues properly and the failure to do so is fault.

31. The Guidance explains it is up to a person to prove they no longer have an asset and says what evidence can be used to do this. Mrs Y provided evidence of no longer having the £30,000 at the start of the first financial assessment. But twice the Council quoted the Guidance wrongly to Mrs X as if Mrs Y had failed to provide some important evidence (see paragraphs 18 and 22 above). That suggests, in coming to its decision about deprivation of assets, the Council took into account irrelevant information and that is fault.

Complaints procedure

32. The Council has explained why it delayed responding to Mrs X's complaint and it has apologised for the delay. The Council kept in touch with her during the delay but largely only in response to her requests for information about progress. The Council was at fault for not proactively advising Mrs X of changes in how long it expected to take to respond to her complaint.

Agreed action

33. Within two months of a final decision the Council will carry out a further financial assessment for Mrs Y, to include a fresh decision on possible deprivation of assets. The assessment will not include consideration of irrelevant information. It will cover the issue of Mrs Y's motivation in gifting £30,000 to family members. It will involve an officer speaking to Mrs Y and maybe other members of the family about why Mrs Y gifted the money at that time and what consideration Mrs Y gave to any potential need for care and support in the future. If the Council comes to a different decision on deprivation of assets it will adjust the charges for Mrs Y's care accordingly.

34. Within one month of a final decision the Council will provide a further apology to Mrs X for failing to keep her properly informed about the progress of her complaint.

Final decision

35. I have completed my investigation because the Council's actions will remedy the injustice caused by its fault.

Investigator's decision on behalf of the Ombudsman

20 February 2018

Complaint reference:
17 015 689

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman will not investigate this complaint about the Council's response to malicious child protection allegations made against the complainant. This is because we cannot achieve the outcomes that the complainant seeks.

The complaint

1. The complainant, who I refer to here as Mrs N, says that the Council:

- Has handled poorly safeguarding procedures following an allegation about the care provided by her for their grandchildren;
- Should have taken into consideration the history of malicious and untrue allegations instigated by the children's paternal grandparents;
- Has refused to remove the allegation from her file; and
- Has not fully complied with a Subject Access Request made by the her and her husband.

The Ombudsman's role and powers

2. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word 'fault' to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. We provide a free service, but must use public money carefully. We may decide not to start or continue with an investigation if we believe we cannot achieve the outcome someone wants. ***(Local Government Act 1974, section 24A(6), as amended)***

How I considered this complaint

3. I considered the information provided by Mrs N and I have sent her a draft decision for her comments.

What I found

4. Mrs N and her husband care for their grandchildren. In August 2017 a child protection referral was made to the Council regarding Mrs N's care.

5. The Council investigated the allegation under its safeguarding procedures, and found it to be unsubstantiated.

6. Mrs N complained, as she said there had been a number of malicious referrals and allegations instigated by her grandchildren's paternal grandparents. All had been shown to be untrue, and Mrs N felt that the Council should have taken this history into consideration in investigating the latest referral.

7. The Council has responded to the complaint, explaining that it has a statutory duty to carry out safeguarding checks in accordance with section 47 of the Children Act 1989, where there is an allegation that a child may be at risk of significant harm. This duty cannot be set aside or considered in the context of previous allegations. Each referral must be considered on its own merits.

8. Mrs N responds that even if the Council did have to investigate this new allegation, it handled it badly. She says there was initial delay in responding, followed by a refusal to wait to interview the child involved until after her 11+ test. She feels that the Council followed some procedures without adequate thought for the effect on the child and the family.

9. The Ombudsman will not investigate the complaint further, however.

10. There is no fault in the Council following up the referral. As it rightly says, it cannot ignore any referral even if there have been previous unsubstantiated allegations from the same source. I recognise that repeated use of the safeguarding procedures would be frustrating or distressing to Mrs N and her family, but we cannot affect or change the fact that the Council must respond to the allegations, even if it suspects they may be malicious.

11. None the less, the Council may wish to consider whether the way it follows up allegations is sufficiently sensitive to the situation and the likely effect on the children involved. I cannot say that its timing of the interview with the child involved affected her performance in the 11+ test, as Mrs N believes, or that it has caused injustice that would warrant further investigation. However, the possibility of causing injustice through an over rigid application of the safeguarding protocols should be a consideration that is taken into account in any future dealings with Mrs N's family.

12. Mrs N has also asked the Council to remove the allegation from her file, and is dissatisfied with its refusal to do so. However, we cannot achieve this outcome, as the Council must keep an accurate record of the allegations triggering the safeguarding procedures. Mrs N does have the right to have the outcome correctly recorded, and to have her own comments added to the file.

13. Additionally Mrs H has complained to the Council that it has not fully complied with an SAR. This complaint is for the Information Commissioner's Office to consider.

14. Finally, Mrs H regards it as unacceptable for the children's paternal family to continue to fabricate allegations. This is not something that the Council either condones or can prevent. Mrs H could consider referring the matter to the police.

Final decision

15. The Ombudsman will not investigate this complaint. This is because there is insufficient evidence that the Council's actions have caused injustice, and we cannot achieve the outcomes that she is looking for.

Investigator's decision on behalf of the Ombudsman

12 February 2018

Complaint reference:
17 015 508

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman will not investigate this complaint that a social worker ignored the complainant's concerns about her mother returning to live with her father after she suffered a wrist injury in 2012. This is because the Ombudsman cannot investigate matters the complainant has been aware of for more than 12 months, unless we decide there are good reasons.

The complaint

1. The complainant, whom I refer to as Mrs B, says a social worker ignored her concerns about her mother returning to live with her father after she suffered a wrist injury. Mrs B says her father was then able to take her mother abroad, where she passed away, and he did not arrange for her to brought home to be buried.

The Ombudsman's role and powers

2. We cannot investigate late complaints unless we decide there are good reasons. Late complaints are when someone takes more than 12 months to complain to us about something a council has done. ***(Local Government Act 1974, sections 26B and 34D, as amended)***

How I considered this complaint

3. I have considered Mrs B's complaint to the Ombudsman. I also gave Mrs B the opportunity to comment on a draft version of this statement.

What I found

4. In my view, the restriction detailed in paragraph 2 above applies to Mrs B's complaint. This is because I understand the events occurred in 2012, and I am unaware of any reasons why Mrs B was prevented from complaining to us sooner. I therefore do not consider the Ombudsman should investigate Mrs B's complaint.

Final decision

5. The Ombudsman will not investigate this complaint. This is because the events occurred more than 12 months ago, and I have seen no grounds to exercise discretion to consider this late complaint now.

Investigator's decision on behalf of the Ombudsman

15 February 2018

Complaint reference:
17 015 719

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman cannot investigate Mr A's complaint about the actions of social workers because it concerns matters which have been decided in court.

The complaint

1. The complainant, who I will refer to as Mr A, complains about the actions of social workers relation to the care of his children.

The Ombudsman's role and powers

2. We cannot investigate a complaint about the start of court action or what happened in court. ***(Local Government Act 1974, Schedule 5/5A, paragraph 1/3, as amended)***

3. The law says we cannot normally investigate a complaint when someone could take the matter to court. However, we may decide to investigate if we consider it would be unreasonable to expect the person to go to court. ***(Local Government Act 1974, section 26(6)(c), as amended)***

How I considered this complaint

4. I have considered what Mr A has said in support of his complaint.

What I found

5. Mr A's children have been the subject of private law proceedings. He complains about the quality of the Section 7 reports prepared by social workers for the court. He also complains that the Council has failed to take proper account of his concerns about his children, who he has been prevented from having contact with.

6. The Ombudsman cannot investigate Mr A's complaint because it concerns matters which have been decided in court. A Section 7 report is produced for the court and the Ombudsman cannot investigate anything relating to its content.

7. Contact with Mr A's children is a matter for the court. If Mr A has concerns about the arrangements for the care of his children or his contact with them he may ask the court to make new orders. The Ombudsman cannot intervene.

Final decision

8. The Ombudsman cannot investigate this complaint because it concerns matters which have been decided in court.

Investigator's decision on behalf of the Ombudsman

13 March 2018

Complaint reference:
17 016 310

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman will not investigate Mr B's complaint about the Council refusing to investigate the conduct of a child protection conference at stage two of its statutory procedures for Children Act 1989 complaints. This is because in all the circumstances an investigation could not achieve a worthwhile result, so it is not warranted. It would be reasonable for Mr B to apply to court for contact with his children, and challenge in court any evidence he disputes which may be put forward by the council in whose area the children now live.

The complaint

1. The complainant, whom I shall call Mr B, says the Council refuses to investigate his complaints about the conduct of a child protection conference in October 2016 at stage two of its statutory procedures for Children Act 1989 complaints. Mr B wants a stage two investigation to expose what he believes are flaws in the Council's actions before he begins court action to restore his contact with his children.

The Ombudsman's role and powers

2. The Local Government Act 1974 sets out our powers but also imposes restrictions on what we can investigate.

3. We investigate complaints about 'maladministration' and 'service failure', which we call 'fault'. We must also consider whether any fault has had an adverse effect on the person making the complaint, which we call 'injustice'. We provide a free service, but must use public money carefully. We may decide not to start or continue with an investigation if we believe:

   - it is unlikely we could add to any previous investigation by the Council, or
   - it is unlikely further investigation will lead to a different result, or
   - we cannot achieve the result someone wants.

   (Local Government Act 1974, section 24A(6), as amended)

How I considered this complaint

4. I considered what Mr B said in his complaint and discussed it with him by telephone. I also gave Mr B an opportunity to comment on a draft before reaching a final decision, and considered his comments.

What I found

5. Mr B complained to the Council that a Child Protection Conference wrongly decided to recommend the Council make Child Protection Plans (CPP) for his children. He says the decision was made before the second part of the conference, which he was to attend. He says the conference therefore pre-judged the matter, before hearing the evidence and allowing him to challenge allegations made by his wife and son.

6. Mr B also says there is evidence his wife, who attended the first part of the conference, had previously made false allegations about him and been charged with wasting police time. So he believes the Council was wrong to treat her evidence as credible without giving him chance to challenge it.

7. The Council has refused to investigate Mr B's complaint at stage two of its procedures. It says an investigation cannot achieve for him the result he wants. Mr B wants the Ombudsman to recommend the Council investigate the complaint as required by law.

8. The Ombudsman does not usually investigate or comment on a council's complaint handling if we are not investigating the underlying matter which is the subject of the complaint. So, regardless of whether the Council is at fault for not carrying out a stage 2 investigation according to the statutory procedures, I must consider whether there would be grounds for us to investigate Mr B's underlying complaint about his dissatisfaction with the Council's original actions. If not, there is no basis for the Ombudsman to recommend the Council carry out a stage two complaint investigation, even if it was at fault in not doing so.

9. The underlying events include:

   - Mr B's wife and two of his children moved into a different council area soon after the events he complains of, which means this Council's involvement with them ended then.
   - One of Mr B's daughters remained living with him, but the Council stopped her CPP after some work by a social work team which led it to conclude the plan was no longer necessary.
   - This Council therefore has no continuing responsibility or involvement with Mr B's family for which the Ombudsman could achieve any worthwhile action by the Council if we investigated.
   - Mr B says his wife left with two of the children and has not stayed in contact with Mr B. He believes she would not have done this if the Council had not told him and his wife one of them must leave the marital home to prevent the Council having to consider more formal action around the children. The Ombudsman cannot, however, know what was in Mr B's wife's mind or what caused her to act as she did.
   - From the correspondence Mr B sent with his complaint it is clear he believes the Council had no basis to act as it did, but the Council is satisfied otherwise. A complaint investigation, whether by the Council or the Ombudsman, would not examine the underlying information the Council was considering, nor would it question the merits of social work decisions and professional judgements. But even if it did, it remains the case there is no action the Ombudsman could recommend or the Council could take which would affect Mr B's family now.
   - Mr B wishes to apply for contact with the two children, and believes a formal decision about the Council's actions towards his family would help his case. If

Mr B wishes to challenge the evidence this Council relied on for its actions and for what may remain on file in the council area where his children now live, he can do so as part of the court's hearing of any application he chooses to make for a child arrangements order, eg to achieve contact with his children. It would not be proper to use public money to investigate simply to provide evidence for use in a private court action. It would be reasonable to expect Mr B to use the court procedure to achieve what he wants, as provided by law. A complaint investigation at stage 2 of the Council's procedures or by the Ombudsman would not be relevant to the matter.

10. There would be no basis for the Ombudsman to investigate the matters which underlie Mr B's complaint, so we shall not investigate or make recommendations about its complaint handling.

Final decision

11. The Ombudsman will not investigate this complaint. This is because in all the circumstances an investigation could not achieve a worthwhile result, so it is not warranted. It would be reasonable for Mr B to apply to court for contact with his children, and challenge in court any evidence he disputes which may be put forward by the council in whose area the children now live.

Investigator's decision on behalf of the Ombudsman