

**16 October 2023****Agenda Item: 4****REPORT OF THE SERVICE DIRECTOR FOR CUSTOMERS, GOVERNANCE  
AND EMPLOYEES****LOCAL GOVERNMENT & SOCIAL CARE OMBUDSMAN DECISIONS  
AUGUST TO SEPTEMBER 2023****Purpose of the Report**

1. To inform the Committee about Local Government & Social Care Ombudsman's (LGSCO) decisions relating to the Council since the last report to Committee was completed and therefore any decisions after 7<sup>th</sup> August 2023.

**Information**

2. Members have asked to see the outcome of Ombudsman investigations regularly and promptly after the decision notice has been received. This report therefore gives details of all the decisions received since the last report to this Committee which was held on 6<sup>th</sup> September 2023.
3. The LGSCO provides a free, independent and impartial service to members of the public. It looks at complaints about Councils and other organisations. It only looks at complaints when they have first been considered by the Council and the complainant remains dissatisfied. The LGSCO cannot question a Council's decision or action solely on the basis that someone does not agree with it. However, if the Ombudsman finds that something has gone wrong, such as poor service, a service failure, delay or bad advice and that a person has suffered as a result, the LGSCO aims to get the Council to put it right by recommending a suitable remedy.
4. The LGSCO publishes its decisions on its website ([www.lgo.org.uk/](http://www.lgo.org.uk/)). The decisions are anonymous, but the website can be searched by Council name or subject area.
5. A total of nine decisions relating to the actions of this Council have been made by the Ombudsman in this period. Appendix A to this report summarises the decisions made in each case for ease of reference and Appendix B provides the full details of each decision.
6. Full investigations were undertaken into five complaints. Appendix A provides a summary of the outcomes of the investigation. Where fault was found, the table shows the reasons for the failures and the recommendations made. If a financial remedy was made the total amount paid or reimbursed is listed separately.

7. There was fault found in three of the five cases. The first case was in Childrens. The complaint was about the way the Council has handled annual reviews of the child's Education, Health and Care (EHC) plan. There were delays in 2021 and 2022 in completing annual reviews and the Council failed to issue a decision with appeal rights when he applied for a statutory reassessment. The Council recognised the delays and apologised. The Council was found at fault overall and as a result has apologised to Ms X, offered a distress payment and is agreeing a payment to recognise the 8 months of missed provision. £5300 will be the total financial remedy. The service is reviewing its procedures, for diary management and managing potential missed deadlines. Following the last Committee meeting I raised the question around the language used in Ombudsman reports that complainants spend the money "as they see fit". The reply was that the Ombudsman has responded to confirm that the wording used in this case is appropriate and in line with their guidance on remedies.
8. The second case is in Childrens. The Council failed to meet its legal duty to secure the provision in Ms Z's Education, Health and Care plan (EHC plan). This caused her to miss out on provision she was entitled to receive between January and May 2022. The Council had already accepted fault and offered Ms Z £1200. The Ombudsman recommended the Council increase the remedy for missed provision to £2,500, in addition to paying Ms Z's mother, Ms X, £300 to reflect the frustration and distress caused to her. The Council did not delay in producing Ms Z's EHC plans, or fail to consider her views as an independent adult, during this complaint period. The issue was around securing provision rather than producing the EHCP. It is worth noting that a lot of work is being undertaken around dealing with complaints and preventing escalation through workshops as well as communication between the departments and the complaints team. If a resident is affected adversely this is recognised by the relevant department, in this case ICDS, and a remedy is suggested earlier and explained to the complainant as well as what is possible if something is out of our control.
9. The third case is in Childrens but the complaint never fully progressed as it was difficult to engage with the complainant due to lack of response despite the Council being very patient. The complaint is about the Council failing to properly support Ms X as a care leaver. She complained staff were rude and the Council did not provide a proper care leaver's grant or support her with housing. The Ombudsman believe that the Council failed to consider the complaint through the appropriate statutory complaints process. The Council put the complaint initially through the corporate process. It is important to note that after initial enquiries it is occasionally possible and feasible to change which process the complaint goes through. We hadn't got as far into the complaint to be able to judge this. However, this did not lead to significant injustice in Miss X's case. There was also found no fault in the support provided to Miss X. The Complaints team did challenge the Ombudsman's draft decision as Ms X had a few other complaints the Ombudsman refused to look at due to being out of timescales. We explained that the complaints team did consider Ms X's first 3 complaint contacts through the children's procedure and she received a Stage 1 response in reply to one of the complaints. As Ms X did not engage with us, we were unable to proceed with these through the children's process or reach the point where we could exercise any discretion to investigate matters which dated back 6-8 years. Usually we only accept complaints for events that occurred in the previous twelve months. Without Ms X's engagement, we could not clarify the details of the complaint therefore offer any discretion in deciding how or whether we could investigate any elements of the historical complaints. However, for the same reasons the LGSCO has stated it seemed that the issues dated back too far, it would be very unlikely we could carry out a fair or thorough investigation. We therefore explained why we could not accept why fault has

been found. The Ombudsman maintained their position. There was no injustice and no actions to be taken on this case.

### **Other Options Considered**

10. The other option considered was not bringing regular reports to the Committee detailing the decisions made by the Local Government and Social Care Ombudsman. This option was rejected as by not having oversight of this report the Committee would not receive assurances that the learnings from Ombudsman cases were leading to improvements in services.

### **Reasons for Recommendation/s**

11. To enable members to scrutinise complaints dealt with by the Council that went to the Ombudsman and to inform them of the service improvements being made for the benefit of residents as well as colleagues.

### **Statutory and Policy Implications**

12. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

### **Data Protection and Information Governance**

13. The decisions attached are anonymised and will be publicly available on the Ombudsman's website.

### **Financial Implications**

14. The details of any financial payments are set out in Appendix A. £8100 will come from Children's services.

### **Implications for Service Users**

15. All of the complaints were made to the Ombudsman by service users, who have the right to approach the LGSCO once they have been through the Council's own complaint process.

### **RECOMMENDATION/S**

- 1) That members note the findings of the Local Government and Social Care Ombudsman and welcome the lessons learned and actions taken in response to the findings

**Marjorie Toward**

**Monitoring Officer and Service Director – Customers, Governance and Employees**

**For any enquiries about this report please contact:**

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### **Constitutional Comments (HD (Standing))**

16. Governance & Ethics Committee is the appropriate body to consider the content of this report. If the Committee resolves that any actions are required, it must be satisfied that such actions are within the Committee's terms of reference.

### **Financial Comments (SES 26/09/2023)**

17. The financial implications are set out in paragraph 12 of the report.

18. The details of the financial payments are set out in Appendix A.

### **Background Papers and Published Documents**

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- None

### **Electoral Division(s) and Member(s) Affected**

- All