1 June 2021

Complaint reference:
20 011 817

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: There was no evidential basis for the Council's decision to reduce Mr Y's support hours. During this investigation the Council reconsidered its decision and reinstated the hours. There is no further remedy required.

The complaint

1. Mr X complains about the outcome of an assessment of his adult son's care and support needs completed in November 2020. The assessment formed part of an agreed remedy on a public report this office issued in November 2019 (18 015 558).

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 the complaint and discussed it with Mr X;
- considered the correspondence between Mr X and the Council, including the Council's response to the complaint;
- made enquiries of the Council and considered the responses;
- considered relevant legislation;
- offered Mr X and the Council an opportunity to comment on a draft of this document.

What I found

5. Mr Y has autism. He lives with his parents, Mr & Mrs X, who provide support with all aspects of daily living.

6. In November 2019, this office published a public report which criticised the Council for its decision to reduce Mr Y's personal budget without proper assessment of his care and support needs. As part of the agreed remedy the Council agreed to *"review Mr Y's assessment and produce a care and support plan which reflects his needs over a seven-day period and explain in detail how these needs will be met, in consultation with Mr Y and Mr & Mrs X".*

7. Due to lockdown, there was a delay in the completion of the assessment. The Council completed the assessment in November 2020. The outcome of which resulted in a reduction in Mr Y's weekly support hours from 13 hours per week to 6.

8. Having considered the needs assessment completed in 2018, the content of which informed the findings of the public report, and the assessment completed in November 2020, I contacted the Council to ask it to explain the basis for its decision to reduce Mr Y's weekly support hours, when the assessment showed little change in his needs.

9. The 2020 assessment considered all areas of Mr Y's needs. Of which:

   - 19 concluded no change from the 2018 assessment
   - 2 concluded increased independence (no 1 & 18 of the assessment)
   - 2 concluded increased need for support (no 5 & 11 of the assessment)

10. The 2018 assessment records Mr Y to need between 3 – 3.5 hrs support a day

11. The November 2020 assessment records Mr Y to need between 4.5 – 5 hours support a day. Both assessments record Mr Y to need support *'in the community more than 6 times a week'.*

12. During this investigation, the Council reconsidered its decision to reduce Mr Y's support hours and agreed to reinstate the support hours to 13 per week and backdate it to November 2020. The Council has issued a revised support plan, which Mr Y and Mr X are satisfied with. The Council plans to review Mr Y's needs again in June 2022.

Analysis

13. It is not our role to decide if a person has social care needs, or if they are entitled to receive services from the Council. Our role is to establish if the Council assessed a person's needs properly and acted in accordance with the law.

14. In this case, the Council failed to do so because there was no evidential basis for the reduction to Mr Y's support hours.

15. If a person's support package is reduced or changed in a significant way, then the law requires that the Council provides a detailed and convincing explanation as to why this is happening (for example because the person's condition has improved substantially). In this case there was no convincing explanation.

16. The Council reconsidered its decision and reinstated Mr Y's hours. There is no outstanding injustice that needs to be remedied. The Ombudsman welcomes the Council's actions.

Final decision

17. There is evidence of fault by the Council. There was no evidential basis for the reduction to Mr Y's support hours.

18. During this investigation, the Council reconsidered its decision and reinstated Mr Y's support hours. There is no further remedy required..

19. It is on this basis; the complaint will be closed.

Investigator's decision on behalf of the Ombudsman

Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against Nottinghamshire County Council (reference number: 19 019 681)

23 June 2021

The Ombudsman's role

For more than 40 years the Ombudsman has independently and impartially investigated complaints. We effectively resolve disputes about councils and other bodies in our jurisdiction by recommending redress which is proportionate, appropriate and reasonable based on all the facts of the complaint. Our service is free of charge.

Each case which comes to the Ombudsman is different and we take the individual needs and circumstances of the person complaining to us into account when we make recommendations to remedy injustice caused by fault.

We have no legal power to force councils to follow our recommendations, but they almost always do. Some of the things we might ask a council to do are:

- apologise
- pay a financial remedy
- improve its procedures so similar problems don't happen again.

Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

Key to names used

Mr C	The complainant
Mrs D	The complainant's mother
X	A family member
Y	A family member
Z	A family friend

Report summary

Adult Social Care

Mr C complained about the standard of care provided to his late mother at a Council commissioned care home, the visiting restrictions imposed on him by the care home, and the Council's safeguarding process which failed to uphold his complaints. Mr C says the Council's failures have caused him personal distress and anxiety and his mother's health deteriorated because of the inadequate care she received.

Finding

Fault found causing injustice and recommendations made.

Recommendations

To remedy the injustice identified in this report we recommend the Council:

- formally acknowledge the failures identified in this report and apologise to Mr C for the frustration, distress, time and trouble the Care Provider's and Council's actions caused him;
- pay Mr C £650 to reflect:
    - the distress he was caused by the Care Provider banning him from the care home without notice;
    - the distress he was caused from not seeing his mother for six weeks; and
    - his time and trouble in having to raise his complaints with both the Care Provider and Council for the restrictions to be removed;
- through contract monitoring processes ensure the Care Provider:
    - reminds care staff about what actions to take before a person is excluded from a care home;
    - reminds care staff about the importance of recording risk assessments and that these are evidence based rather than opinion;
    - provides training to staff about anti discriminatory recording and behaviours;
- remind staff about the importance of telling people the outcome of safeguarding investigations as quickly as possible;
- remind staff about recording and completing any follow up actions arising from a safeguarding investigation.

The Council has accepted our recommendations.

The complaint

1. Mr C complained about services provided at Berry Hill Park Care Home, to his late mother, Mrs D. We have used Mr C and Mrs D rather than real names to protect anonymity.
2. Mr C complained about:
   - the care Mrs D received in Berry Hill Park Care Home;
   - wrongly put in place deprivation of liberty safeguards to prevent him from taking Mrs D out of the care home;
   - the Council's best interest decision Mrs D should remain at Berry Hill Park Care Home; and
   - the Council's safeguarding investigation.
3. Because of these failures Mr C considers the Care Provider neglected Mrs D and she did not receive the care she should have. He also believes he lost time with his mother after the care home inappropriately restricted his access to her. Mr C says the Council's failures caused him distress and frustration.

Legal and administrative background

The Ombudsman's role and powers

4. We investigate complaints about 'maladministration' and 'service failure'. In this report, we 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. We 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)***
5. 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)***
6. We investigate complaints about councils and certain other bodies. Where an individual, organisation or private company is providing services on behalf of a council, we can investigate complaints about the actions of these providers. ***(Local Government Act 1974, section 25(7), as amended)***
7. When a council commissions another organisation to provide services on its behalf it remains responsible for those services and for the actions of the organisation providing them. So, if we find fault with the actions/service of the care provider, we make recommendations to the council.
8. We normally name care homes and other providers in our reports. However, we will not do so if we think someone could be identified from the name of the care home or care provider. ***(Local Government Act 1974, section 34H(8), as amended)***
9. We normally expect someone to refer the matter to the Information Commissioner if they have a complaint about data protection. However, we may decide to investigate if we think there are good reasons. ***(Local Government Act 1974, section 24A(6), as amended)***

Relevant law and guidance

The Care Act 2014

10. Section 42 of the Care Act 2014 says a council must make necessary enquiries if it has reason to think a person may be at risk of abuse or neglect and has needs for care and support which mean he or she cannot protect himself or herself. It must also decide whether it or another person or agency should take any action to protect the person from abuse or risk.

The Mental Capacity Act 2005 and Code of Practice to the Mental Capacity Act

11. The Mental Capacity Act 2005 is the framework for acting and deciding for people who lack the mental capacity to make decisions for themselves. The Act (and the Code of Practice 2007) describes the steps a person should take when dealing with someone who may lack capacity to make decisions for themselves.

12. A key principle of the Mental Capacity Act 2005 is that any act done for, or any decision made on behalf of a person who lacks capacity must be in that person's best interests. Section 4 of the Act provides a checklist of steps that decision makers must follow to determine what is in a person's best interests. The decision maker must also consider if there is a less restrictive choice available that can achieve the same outcome.

13. The Deprivation of Liberty Safeguards (DoLS) is an amendment to the Mental Capacity Act 2005 and came into force on 1 April 2009. The safeguards 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. 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 to follow to obtain authorisation to deprive an individual of their liberty. Without the authorisation, the deprivation of liberty is unlawful.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

14. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations) set out the requirements for safety and quality in care provision. The Care Quality Commission (CQC) issued guidance in March 2015 on meeting the regulations (the Guidance.). We consider the 2014 Regulations and the Guidance when determining complaints about poor standards of care.

15. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 12 – "Safe care and treatment". Providers must assess the risks to people's health and safety during any care or treatment. Guidance says providers must do what is reasonably practicable to mitigate risks;
- Regulation 13 – "Safeguarding service users from abuse and improper treatment". This regulation says a person should not be deprived of their liberty without lawful authority;
- Regulation 14 – "Meeting nutritional and hydration needs". Providers must ensure people have enough to eat and drink to meet their nutrition and hydration needs and receive the support they need to do so. This is to reduce risks of malnutrition and dehydration.
- Regulation 17 – 'Good governance'. Providers must have systems and procedures to assess, monitor and mitigate any risks relating to the health,

safety and welfare of people using services. Providers must also maintain accurate, complete and detailed records for each person using the service.

16. CQC's "Information on visiting rights in care homes – detailed version" says care home visits for those who lack mental capacity should be enabled unless there are compelling reasons to say the visits are not in their best interests.

Human Rights Act 1998

17. The Care Act 2014 says CQC regulated Care Providers are acting as public authorities for the purposes of the Human Rights Act 1998 (HRA) if a local authority funds/arranges a person's care. This means that if a local authority funds/arranges a person's care then the Care Provider is a public authority and so the person gets the protection of the HRA.

18. The Human Rights Act 1998 brought the rights in the European Convention on Human Rights into UK law. Public bodies, including councils, must act in a way to respect and protect human rights. It is unlawful for a public body to act in a way which is incompatible with a human right. 'Act' includes a failure to act. ***(Human Rights Act 1998, section 6)***

19. It is not our role to decide whether a person's human rights have been breached. That is for the courts. We decide whether there has been fault causing injustice. Where relevant, we consider whether a council has acted in line with legal obligations in section 6 of the Human Rights Act 1998. We may find fault where a council cannot evidence it had regard to a person's human rights or if it cannot justify an interference with a qualified right.

20. Article 5 of the European Convention on Human Rights says everyone has the right not to be deprived of their liberty except in limited cases including the detention of someone who is of "unsound mind".

21. Article 8 of the European Convention on Human Rights says everyone has a right to respect for their private and family life, home, and correspondence. This right is qualified which means it may need to be balanced against other people's rights or those of the wider public. A qualified right can be interfered with only if the interference is designed to pursue a legitimate aim, is a proportionate interference and is necessary. Legitimate aims include:

- the protection of other people's rights;
- national security;
- public safety;
- the prevention of crime;
- the protection of health.

Equality Act 2010

22. The Equality Act 2010 protects the rights of individuals and supports equality of opportunity for all. It offers protection, in employment, education, the provision of goods and services, housing, transport and the carrying out of public functions.

23. The Equality Act makes it unlawful for organisations carrying out public functions to discriminate on any of the nine listed protected characteristics. The Public Sector Equality Duty also sets out duties for such organisations to follow to stop discrimination. The 'protected characteristics' referred to in the Act are:

- age,
- disability,

- gender reassignment,
- marriage and civil partnership,
- pregnancy and maternity,
- race,
- religion or belief,
- sex, and
- sexual orientation.

24. Direct discrimination occurs when a person or service provider treats another less favourably than they treat or would treat others because of a protected characteristic.

How we considered this complaint

25. We spoke with Mr C, considered written information he provided and made enquiries of the Council. We considered:

- the Council's response, and documents provided by both Mr C and the Council. This included safeguarding and case records;
- Care and Support Act 2014;
- Care and Support Statutory guidance (CASS);
- Mental Capacity Act 2005;
- Deprivation of Liberties Safeguards;
- The Equality Act 2010;
- Human Rights Act 1998.

26. Mr C, the Council and Care Provider had an opportunity to comment on our draft report. We considered any comments received before producing the final report.

What we found

Background information

27. Mrs D and Mr C lived together in the community. Mr C has a history of mental health problems. After Mrs D developed dementia Mr C became her main carer. Because of an increase in Mrs D's care needs she moved into Berry Hill Park Care Home, a residential care home run by HC-One Limited, the "Care Provider". The Council arranged and funded the care home. Mr C continued to support his mother visiting daily.

28. Mrs D had a close family member, who we refer to as X. X lived abroad but visited the country once or twice a year. When in England X saw Mrs D regularly, as did another family member, who we refer to as Y. Mr C says Mrs D had fallen out with X and Y and had little contact with them before moving into the care home.

29. There is no dispute that Mr C and X were concerned about Mrs D's welfare. However both had different views on how the Council should meet Mrs D's needs.

What happened

30. In August 2018, the Care Provider made a safeguarding alert to the Council as Mr C threatened to move Mrs D after he found her bruised. Mr C says the Care Provider did not warn him about the bruising, and he only found out when he

visited the care home and saw his mother. The Care Provider told him they forgot to contact him. Mr C says this was not an isolated incident and on at least three further occasions Mrs D had been at risk. Mr C also alerted the Council that Mrs D did not have a DoLS in place.

31. A few days later the Care Provider said Mr C had become loud and aggressive after he saw X visiting Mrs D. The Care Provider said some of the altercation happened in the main lounge in front of other residents, some of whom felt threatened. Mr C had not however aimed any of his anger at the residents or staff.

32. A staff member escorted Mr C out of the care home. Within 20 minutes Mr C had calmed down and apologised to the staff member. Following the incident the Care Provider wrote to Mr C banning him from the care home. The Care Provider did not give Mr C any warning nor did it discuss its concerns before the ban. At the time the Care Provider did not have a specific policy or process in place for visitor restrictions.

33. During the safeguarding investigation the care home raised further concerns about Mr C which included:

- Mr C providing personal care to Mrs D with Z, a family friend;
- Mr C's preference for some carers over others and only wanting those carers to provide care to Mrs D;
- Mr C was verbally "abusive" and threatening to staff members;
- Mrs D was often anxious after Mr C's visit;
- personal comments about Mr C and the way some staff felt around him, that he made them feel uncomfortable, negative comments about his appearance, demeaner and "different" behaviour.

34. Mr C says these were all false allegations.

35. As part of the safeguarding investigation the Council interviewed members of staff, asked for Mr C's views and those of other family members, and reviewed care records.

36. Over the next few weeks Mr C made both safeguarding alerts and complaints to the Council, he also started to look at an alternative care home. The Council dealt with these together. They included:

- Mrs D did not always have access to water;
- Mrs D was often in soiled or wet clothing and left to urinate in public places;
- Mrs D did not receive acceptable personal care;
- the Care Provider was short staffed and could not properly care for residents;
- the Care Provider's inability to manage Mrs D's mobility;
- lack of social stimulation for Mrs D;
- the failure to meet Mrs D's religious needs. Although a priest visited the care home regularly the care home prevented Mr C from taking his mother to church;
- the Care Provider's discrimination against him because of his mental health problems. He says because of this the Care Provider gave more weight to X's views and preferences than his;

- inappropriately shared information with X; and
- contacted Z about an incident without telling Mr C first.

37. After the Care Provider imposed restrictions on Mr C his relationship with staff members worsened. Mr C felt Mrs D should move to a different care home or return home to live with him.

38. Alongside the safeguarding investigation a separate Council department undertook assessments as part of DoLS. The Care Provider had asked for an urgent authorisation as it felt the way in which it provided care to Mrs D could potentially be a deprivation of her liberty.

39. The DoLS assessor interviewed members of staff, considered care records, met with Mrs D, and spoke with Mr C. The assessor also considered the restrictions on Mr C.

40. Both the safeguarding investigating officer and the DoLS assessor criticised the way in which the Care Provider had acted in banning Mr C from the care home. It failed to:

- properly consider Mrs D's right to family life, a potential breach of her Article 8 rights;
- properly record or evidence any of the claims it was making in defence of its actions or the safeguarding alert; and
- engage with Mr C with a view to taking less restrictive action.

It also imposed a ban without any tangible evidence that Mrs D or anyone else, staff member or resident was at risk from Mr C. And appeared to apply a ban to Z, a frequent visitor to Mrs D without any proper cause or reason.

41. The DoLS assessor concluded Mrs D was deprived of her liberty but that it was necessary and the least restrictive option available to maintain her care and safety. By this time, the Care Provider had agreed restricted access between Mr C and Mrs D. It said the first visits would be in public areas and supervised. The DoLS authorised the deprivation but for a shorter period than usual to give the Care Provider an opportunity to resolve matters with Mr C and for the assessor to review the authorisation.

42. The Council completed a best interest assessment. After considering the views of all those involved both family and professionals, it decided that it was in Mrs D's best interest to remain at the care home.

43. The safeguarding investigation into Mr C's allegations about the Care Provider concluded that:

a) another resident had superficially bruised Mrs D while trying to move her away from their personal space;

b) there were times when staff found Mrs D in communal areas wet or soiled. This was mainly due to Mrs D not always cooperating with staff in a toileting schedule, and Mrs D's incontinence which meant she did not always know when she needed to use the toilet;

c) Mrs D would have no access to water when the Care Provider was refilling water jugs;

d) there was weight loss but there was nothing to suggest this was because of poor nutrition but more likely than not because of reduced swelling from an oedema in Mrs D's leg; and

e) the staffing ratio within the care home met government guidelines. There may have been occasions when Mrs D did not receive personal care, but this was generally when the staff were unable to engage with Mrs D rather than out of neglect.

44. The Council recorded (a) to (c) as substantiated concerns.

45. The Council did not uphold Mr C's complaints about the care Mrs D received. It wrote to Mr C on 15 January and 14 February 2019 providing the outcome of the safeguarding and complaint investigation. It said the Care Provider had taken suitable action:

- it had referred Mrs D to both the falls clinic and the incontinence service;
- care staff were now observing Mrs D every 15 minutes;
- the Care Provider had recorded incidents and considered how to prevent reoccurrence and got medical advice when necessary;
- there had been no data breach;
- following a best interest assessment which included gaining views from all those involved; it was not in Mrs D's best interests to attend church. This was because of Mrs D's general frailty and the risk Mr C would not return her to the care home; and
- the Care Provider accepted a staff member had mistakenly contacted Y instead of Mr C and apologised for this.

46. As a result the Care Provider acted to:

- ensure staff replaced water jugs quickly and residents had access to drinks all the time;
- put in place risk assessments to prevent future altercations between Mrs D and other residents; and
- devise a policy about steps care homes should follow if they are considering restricting access to visitors.

47. The Council says the Care Provider supported Mrs D with several activities to provide her with social stimulation and that she engaged with other residents and staff members.

48. By October 2018 the relationship between the Council and Mr C had worsened and Mr C no longer trusted the Council to make unbiased judgements. He felt both the Council and Care Provider sided with X.

49. Mrs D went into hospital in February 2019 and died soon after.

Conclusions

Context

50. This was a complicated case involving difficult family dynamics and many safeguarding allegations and counter allegations. The case records show the Council officers involved were empathetic and impartial. Officers were navigating a difficult family situation while keeping Mrs D at the heart of decision making. The records show officers obtaining the views of all involved, responding to Mr C's frequent emails but also maintaining lines of communication with the care home.

Quality of care at Berry Hill

51. Through its safeguarding investigation the Council identified service failure. Some of the Care Provider's actions were not in line with the regulatory standards, detailed in paragraph 15 above. The Care Provider failed to:

- meet hydration needs by Mrs D not always having easy access to water, (Regulation 14),
- provide safe care and treatment by not addressing Mrs D's incontinence issues, (Regulation 12); and
- protect Mrs D from injury, (Regulations 12 and 17).

52. There is also a lack of record about the activities available to Mrs D and how staff encouraged her to join in these activities. This is fault and not in line with Regulation 17.

53. Mrs D has now died, and we cannot remedy any injustice the Care Provider's actions may have caused her. Mr C has however had time and trouble in raising these issues and anxiety that Mrs D was not receiving the care she should have.

54. There is no fault in the way the Council and the care home decided whether it was in Mrs D's best interests to have church visits. Through the DoLS process the Council obtained views of those involved and made a reasoned decision following the best interest check list. Although Mr C is unhappy with the outcome of the decision, we are unable to criticise decisions where there is no fault in the steps taken in reaching that decision.

55. We do not intend to investigate the alleged data breach as this is a matter for the Information Commissioner.

Restricting Mr C's access to the care home

56. The Care Provider was at fault for failing to properly consider its decision to ban Mr C from the care home. It failed to properly consider whether the ban on Mr C was necessary, the least restrictive, and in Mrs D's best interests. This is not in line with Regulation 13.

57. When the Care Provider lifted restrictions on Mr C's access to Mrs D, it did so conditionally. However there appears to be no risk assessment or rationale about what and how the care home should impose these restrictions. The lack of clear recording and risk assessments are not in line with regulatory standards in particular Regulations 12 and 17.

58. The Care Provider did not consider the impact on Mrs D, or look at ways it could support Mrs D to see her son and limit any potential risk. It did not have a policy that staff could follow and did not give Mr C formal warning before the ban. Both the Council and Care Provider also failed to communicate with Mr C about whether Z could visit. This resulted in neither of them visiting.

59. We consider the Care Provider's restrictions were also not in line with Mrs D's human rights, in particular her right to family life, Article 8. Mrs D was close to Mr C, he visited every day and had lived with her before she went into the care home. The Care Provider's actions interfered with this fundamental right with no clear evidence of how it had reached the decision or attempted to look at ways in which it could avoid the interference.

60. The Equality Act says Care Providers should not discriminate unlawfully against a person with a protected characteristic, this includes mental health problems. The comments made by care home staff about Mr C indicate the Care Provider's

actions were clouded by perceptions they had of Mr C because of his behaviour. This gives cause for concern that Mr C's mental health problems influenced its decision making. The focus was on the irregularity of Mr C's behaviour rather than how anything he did negatively affected Mrs D or others within the care home.

61. The personal comments made about Mr C, and how staff felt around him were opinion and not evidence based. They were criticised by both the DoLS assessor and safeguarding officer. While we understand the Care Provider acted in what it thought was in its, and Mrs D's best interests, the decision making was flawed because of those judgements and not in the spirit of the Equality Act.

62. Mrs D had dementia so continuity and familiarity would have been important. We therefore consider it is more likely than not Mrs D missed Mr C's visits. Mrs D has now died, and we cannot remedy any injustice the Care Provider's actions caused.

63. The Care Provider's actions have however caused Mr C anxiety, distress and frustration which exacerbated his pre-existing mental health problems. Mr C could not visit his mother for approximately six weeks, the Care Provider made the decision without any proper risk assessment, warning or discussion. Mr C lost faith in both the Care Provider and the Council which then impeded his ability to work with them to support his mother.

64. The Care Provider does now have a policy which is in line with good practice and the law. It is unclear whether this was developed because of this complaint, but the proactive steps taken by the Care Provider are welcomed.

Safeguarding

65. The Council followed the Care Act and associated guidance set out at paragraph 10 above. It correctly took safeguarding action when it received alerts initially from the Care Provider and then from Mr C. It investigated the concerns raised and interviewed all relevant parties including Mr C, the care home, family members and other professionals involved. The investigating officer visited Mrs D and considered the use of an advocate.

66. The Council completed a balanced investigation reaching a decision on the allegations made. We are generally unable to criticise a professional judgement unless there is procedural fault. While we understand Mr C is unhappy with the outcome of the investigation about Mrs D's care, we are unable to find fault with the Council's actions.

67. We understand the Council's reasons for combining the safeguarding issues with Mr C's complaints. However we consider this caused some confusion about outstanding care issues and a delay in telling Mr C the outcome of the safeguarding investigation. Even though this was a difficult situation we consider the Council should have told Mr C the outcome of the investigation into him sooner. It should have also set out what follow up actions it intended to take about Mr C's concerns about his mother's care. This would have relieved some of Mr C's anxiety and frustration of having unfounded allegations weighing over him, and reassurance that the Council was listening and taking action about Mrs D's care.

Best interest decisions about Mrs D remaining at the care home

68. It is understandable that Mr C would have lost trust and confidence with the Care Provider, however the focus of the Council was Mrs D. The decision it had to make was whether it was in her best interests to leave the care home, and if it

was, where she should live. We have found no fault in the way the Council completed the best interest assessment. It followed the best interest checklist, considered the views of all those involved, and made a reasoned decision that moving Mrs D would be damaging to her health and wellbeing. There was also no other option available, that could meet Mrs D's needs.

69. Even if there was fault in the decision making process it is unlikely Mrs D would have moved to a different care home. This is because at the time Mr C's choice of care home did not have a vacancy.

Recommendations

70. We consider there was fault by the Council and the Care Provider which caused Mr C and Mrs D injustice. Mrs D has died, and we cannot remedy her injustice. We made recommendations to the Council which it has agreed. The actions are to improve future practice and to recognise the impact the faults had on Mr C.

71. The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

72. In addition to the requirements set out above, the Council has agreed to:

- formally acknowledge the failures identified in this report and apologise to Mr C for the frustration, distress, time and trouble the Care Provider and Council's actions caused him;
- pay Mr C £650 to reflect:
    - the distress caused by the Care Provider banning him from the care home without notice;
    - the distress of not seeing his mother for six weeks; and
    - his time and trouble in having to raise his complaints with the Care Provider and Council for the restrictions to be removed;
- through contract monitoring processes ensure the Care Provider:
    - reminds care staff about what actions to take before excluding a person from a care home;
    - reminds care staff about the importance of recording risk assessments and that these are evidence based rather than opinion;
    - provides training to staff about anti discriminatory recording and behaviours;
- remind staff about the importance of telling people the outcome of safeguarding investigations as quickly as possible;
- remind staff about recording and completing any follow up actions arising from a safeguarding investigation.

73. Mr C says he will not accept the Council's apology or payment because nothing will remedy the consequences of the Council's actions.

Decision

74. We have found fault by both the Council and the Care Provider acting on behalf of the Council which has caused Mr C and Mrs D injustice. We consider the agreed actions above are suitable to remedy the complaint.

75. As there is a potential breach of the regulatory standards under the information sharing agreement between the Local Government and Social Care Ombudsman and the Care Quality Commission (CQC), we will share this decision with CQC.

23 July 2021

Complaint reference:
20 007 088

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Mr X complained about the Council's refusal to obtain an independent valuation of jointly owned property when assessing his contribution towards residential care home fees. We find the Council was at fault for not doing so. The Council has already agreed to arrange a valuation. The Council has also agreed to apologise for not doing so sooner.

The complaint

1. Mr X complains the Council failed to carry out a proper financial assessment of jointly owned capital assets.
2. This led to him being unable to pay his care home fees, leaving his care home placement in jeopardy.
3. Mr X is represented by his wife, Mrs X and their solicitor in making this complaint.

The Ombudsman's role and powers

4. 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)***
5. 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)***
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)***

How I considered this complaint

7. I considered the information provided by Mr X's representative.
8. I considered the Council's replies to my enquiries.
9. I considered relevant law and guidance as set out below.
10. The Council and Mr X had the opportunity to comment on my draft decision. I considered comments before making a final decision.

What I found

Relevant law and guidance

11. The "Care and Support (Charging and Assessment of Resources) Regulations 2014" and the "Care and Support Statutory Guidance 2014" (The Guidance) set out the charging rules for residential care. The Council must follow these rules when carrying out a financial assessment to decide how much a person should pay towards the costs of their residential care.

12. The rules say people who have capital over the upper limit (£23,250) should pay the full cost of their residential care home fees.

13. Where the parties cannot agree the value of a property, the council should ask a professional valuer to provide a current market valuation.

14. Where the value of a property is disputed, the aim should be to resolve this as quickly as possible. Local authorities should try to obtain an independent valuation of the person's beneficial share of the property within the 12-week disregard period where a person is in a care home. ***(The Guidance, Annex B).***

What happened

15. In July 2019, Mr X went into residential care on a permanent basis. He had dementia and lacked capacity to deal with his finances. His wife, Mrs X, does so on his behalf. She instructed a solicitor to represent her in making a complaint to the Council.

16. Mr and Mrs X jointly own a property letting business ("the Business"). This is a partnership arrangement.

17. Mrs X advised the Council that Mr X's finances had fallen below the relevant threshold. Because of this she asked the Council to carry out a financial assessment with a view to receiving aa contribution towards the cost of the care home.

18. In November 2019, following a financial assessment, the Council informed Mrs X that Mr X's capital assets derived from the Business were above the threshold and so Mr X was not entitled to financial support.

19. Mrs X disagreed with this assessment. She told the Council the Business provided an income stream, but their business model meant it had little capital value.

20. Mrs X said all Mr X's available capital has been depleted and she was unable to pay for his care home placement and it was in jeopardy.

21. She complained to the Council on the following grounds:

    - The Council was wrong to rely on a Zoopla valuation to value the Business's capital assets.
    - The Council was wrong to insist the Business's properties should be sold on an individual basis. This is because it failed to take into consideration the properties were jointly owned by Mr and Mrs X.
    - The Council's assessment did not take account of the Capital Gains Tax implications of selling the Business assets in the way it proposed.

22. Mrs X asked the Council to obtain an independent valuation as required by Annex B, paragraph 18 of The Guidance.

23. The Council refused and so Mrs X brought her complaint to the Ombudsman.

Analysis

24. In response to the Ombudsman's enquiries about this complaint, the Council has expressed its wish to reach a negotiated settlement. With this in mind, it has agreed to commission an independent valuation of the Business. This will inform the decision as to whether Mr X qualifies for financial assistance.

25. While I welcome this, the Council should have taken this approach much earlier. Annex B of The Guidance is clear where there is a dispute over the value of capital assets, as was clearly the case here, an independent valuation should be obtained.

26. Putting a valuation on Mr X's capital assets is not a straightforward matter. There are a number of complicating factors, such as Mrs X's position and the occupancy of the properties. It is understandable why Mrs X felt a Zoopla valuation could not take into account the many variables involved. Her rationale for disputing this was justifiable and so was her request for an independent valuation. For this reason, I have found the Council to be at fault for not doing so sooner. This has caused an injustice that requires a remedy.

Agreed action

27. Within eight weeks from the date of my final decision, the Council has agreed to take the following action:

a) Apologise in writing to Mr and Mrs X.

b) Arrange an independent valuation of Mr X's share of the jointly owned business. The Council should liaise with Mrs X to agree instructions to the valuers. The valuation obtained should inform a revised financial assessment. If this results in Mr X being entitled to Council support, this should be backdated to the relevant date.

Final decision

28. The Council was at fault by not obtaining a valuation of Mr X's assets. The Council has agreed an appropriate remedy. On this basis I have completed my investigation

Investigator's decision on behalf of the Ombudsman

11 August 2021

Complaint reference:
20 011 879

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Mr X complained about how the Council considered his complaint under the children's statutory complaint procedure in relation to its actions towards his grandchild, R's, care following the death of their mother. The stage 2 investigation failed to identify the Council's failure to carry out R's health assessments in line with statutory timescales which was fault. This led to frustration and unnecessary time and trouble to Mr X. The Council agreed to apologise to Mr X and remind staff to carry out health assessments for looked after children in line with statutory timescales.

The complaint

1. Mr X complained about how the Council considered his complaints under the children's statutory complaints procedure around its actions towards his grandchild, R's, care following the death of their mother. Specifically, Mr X complained the Council;
   - failed to follow High Court guidance and consider the need to obtain an Interim Care Order for R at the earliest opportunity after their mother's death;
   - allowed R to live with their paternal family without consulting their maternal family; and
   - failed to record Mr X's wishes to be R's carer at the earliest opportunity.
2. Mr X stated R experienced harm as result of the Council's faults.

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. 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)***
5. 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

6. I read the documents Mr X provided and discussed the complaint with him.

7. I considered the documents provided by the Council in response to my enquiry letter.

8. Mr X and the Council had an opportunity to comment on my draft decision. I considered any comments received before making a final decision.

What I found

Children's Statutory Complaints Procedure

9. There is a formal procedure, set out in law, which the Council must follow to investigate certain types of complaint involving children and young people. It involves three stages:

   - local resolution by the Council (Stage1);
   - an investigation by an investigator, overseen by an independent person, who will prepare a detailed report and findings (stage 2). The Council then issues an adjudication letter which sets out its response to the findings; and, if the person making the complaint requests it;
   - an independent panel to consider their representations (Stage 3).

10. When the council has investigated a complaint under the children's statutory complaints procedure, the Ombudsman would not normally reinvestigate it unless we find evidence of fault. We may consider specific issues that have been dealt with under the children's statutory complaints procedure such as the council's failure to follow statutory guidance.

High Court Guidance

11. Case law (In the matter of A and B [2010] EWHC 3824) has established High Court Guidance which sets out 13 points of action a council should consider in cases where one parent kills another. It states the council should give immediate consideration to the issue of legal proceedings, and that it is not appropriate to leave the extended family to resolve matters through family court proceedings. The guidance also states that a children's guardian should be appointed at the earliest opportunity and the case should be transferred to the High Court for urgent consideration.

Health assessment and care reviews for a looked after child

12. The Children Act 1989 guidance and regulations puts a statutory duty on the council to review the care plan of a child that it looks after. This is called a Looked After Child (LAC) review. The guidance states the first review should happen 20 days after the child first becomes looked after, the second within three months of the first review and third and subsequent reviews within six months. The Council should gather information from any relevant person, such as health professionals, to consider how the child's care plan is meeting their needs and if the plan needs updating. The review must consider the child's most recent health assessment.

13. The guidance says when a child becomes looked after by the council it must arrange for a health assessment of the child by a registered medical practitioner. The aim is to identify any health issues that might need attention and to provide a starting point from which the council can monitor the child's health. The council should arrange for a health assessment to take place once every six months for

children under five years old. The cycle of health assessments should start from the date of the first review and continue for as long as they are looked after.

What happened

14. The Council received a safeguarding referral for R from the police. It stated that R's father had killed their mother and that he was under arrest. R's father had arranged for R to stay with a relative before the police arrested him. The Council immediately began a safeguarding enquiry. It obtained an interim care order and the court awarded Mr X a Special Guardianship Order for R ten months after the referral. Between this period, R remained living with paternal relatives.

15. Mr X complained to the Council and said its poor handling of R's case meant the child stayed with paternal relatives for longer than necessary and experienced neglect.

16. The Council decided to bypass stage 1 of the children's statutory complaints procedure and to investigate his complaint at stage 2. This was because of the serious nature of the incident and the issues raised by Mr X. The Council appointed an investigator and an independent person and they agreed the record of complaint with Mr X. There were 37 points of complaint.

17. During the investigation, the Investigator interviewed Mr X and key members of Council staff, reviewed the Council's electronic records and considered the relevant legislation, High Court guidance and Council procedures. Following completion of the investigation, the Council issued an adjudication letter to Mr X. The investigation did not uphold 32 points, made no findings on 4 points and partially upheld 1 point of complaint.

18. In relation to the specific complaints raised with the Ombudsman, the Council made the following findings:

- failure to follow the High Court guidance – Not upheld - the Investigator found the Council took immediate steps to obtain parental responsibility for R at the same time as the legal proceedings to get an interim care order;
- Council allowed R to live with their paternal family without consulting their maternal family – Not upheld – the Investigator's report stated R's father had already placed them with their paternal family before the Council's involvement. The investigation also stated records showed Mr X expressed consistently that R should remain living with their paternal family member;
- failure to record Mr X's wishes to care for R at the earliest opportunity – Not upheld - the Investigator's report stated once Mr X expressed a wish to have R in his care the Social Worker did an initial assessment; and
- R's initial weight and possible neglect - Not upheld - the investigation found while R did lose weight they were not malnourished. It found the statutory health assessment did not raise any concerns about weight.

19. Unhappy with the Council's response Mr X asked it to consider the complaint at stage 3. Mr X stated the stage 2 Investigator did not carry out the investigation fairly and failed to consider all the evidence he provided.

20. The stage 3 independent panel considered Mr X's complaint. Mr X told the panel the issues he wished it to consider were:

- The Investigator's impartiality. Mr X stated they had taken the Council's responses as factual even when he provided contradictory evidence.

- R's weight and possible neglect while they lived with their paternal family. Mr X said the Council was aware that R lost weight but kept this hidden from him and his partner.
- The Council's failure to follow the High Court guidance and consider legal proceedings at the earliest opportunity and ignored his, and his partner's, wishes to be considered as R's carers at the earliest opportunity. Mr X said proceedings only happened after he had prompted the social worker to do so.

21. In relation to R's weight and possible neglect, the panel asked for further information from the Investigator. The Investigator stated that at each LAC review the Health Visitor provided health information and nobody raised concerns about R's weight.

22. The panel agreed with the Investigator's findings and conclusions. It found the Investigator had conducted the stage 2 investigation fairly and thoroughly.

23. The Council wrote to Mr X and told him it was satisfied the Investigator's report was thorough and detailed and the panel agreed with the Investigator's findings and conclusions at stage 2.

24. Dissatisfied with the Council's response Mr X complained to us.

My investigation and findings

25. Where councils have completed the statutory procedure, the Ombudsman does not normally re-investigate the complaint itself. The exception would be where there was evidence of fault in how the stage 2 or stage 3 elements were conducted or if there are specific issues to consider.

26. Mr X brought the same complaints to us which he raised with the stage 3 panel. I have therefore reviewed the Council's findings in those areas. I have explained the information I considered and my finding on each issue.

Impartiality of the Stage 2 Investigator

27. There is no evidence to support Mr X's complaint that the Investigator was biased. The complaint process was carried out in line with the legislation. The Investigator made a finding on each complaint and all but one of these were robust and evidence-based. I have explained below at paragraph 36 the reasons why I disagree with one of the Stage 2 findings.

Failure to follow the high court guidance

28. The records show within 24 hours of receiving the referral from the police for R the Council called an out of schedule legal planning meeting. It arranged the meeting for nine working days later so it could make enquiries. It called the meeting on the basis the threshold set out in the High Court Guidance was met. At the meeting the Council decided to apply for an Interim Care Order, in line with the guidance.

29. I have reviewed the records and agree with the Investigator's finding on this point. The Council followed the High Court Guidance at the earliest opportunity. The Council was not at fault.

The Council allowed R to live with their paternal family without consulting their maternal family

30. The records show R was already in the care of their paternal family before the Council's involvement. The Council had no reason to remove R from their care at that time, and it had no power in which to do so as there was nothing to suggest R was at risk of harm.

31. The Social Worker recorded on a number of occasions that Mr X was happy for R to remain with their paternal family immediately after their mother's death. Mr X states the Social Worker misrepresented his response. He said he did not know of any reason that R should not live with their paternal family member rather than that he agreed they should.

32. I was not there and cannot confirm what was said or not. Regardless of how the social worker recorded and represented Mr X's response, the records show the Council did consult with Mr X on a number of occasions. It was not the Council's decision to place R with the paternal family. I agree with the Investigator's findings on this point. The Council was not at fault.

Failure to record Mr X's wishes to care for R at the earliest opportunity

33. On the day the council became involved in R's care the Social Worker contacted Mr X by telephone. Records show Mr X told the Social Worker he and his partner were foster carers and could care for R. Six days later the Social Worker visited Mr X at home and recorded he was willing to care for R long-term if he was assessed as appropriate. Ten days later the Child and Family Assessment (CFA) recorded there were two family members who were willing to care for R long-term, one being Mr X and the other R's paternal family member. Four days later Mr X sent an email to the Social Worker and said he considered himself, and his partner, as candidates for R's kinship care.

34. 15 days later the Social Worker recorded in the case notes that she called Mr X as he was *"now putting himself forward as a long-term carer for* [R]*"*. The Social Worker started the initial assessment two days later, which was five weeks after the Council first became involved in R's care. The council completed the initial assessment before the first court hearing. The Court ordered the Council to complete viability assessments on both potential carers to assess their suitability as long-term carers for R.

35. The records show the Social Worker recorded Mr X's wishes for it to consider him as a long-term carer for R. The Council then carried out the assessment without delay and well within the 10-12 week timescales set out in relevant guidance. The Council completed the assessment, along with the one it carried out on the family member from R's paternal side prior to the first court hearing. The Council was not at fault and further investigation would not achieve anything further or lead to a different outcome.

R's weight and possible neglect

36. I have reviewed the available documentation and disagree with the Investigator's findings on this point.

37. The Investigator stated the Health Visitor provided information at each LAC review and did not raise any concerns.

38. The records show R had the first health assessment in September which recorded their weight. At the LAC review in November the Health Visitor said R had gained 'some weight' but did not provide any measurements. The Health Visitor was given an action to refer R to a dietician.

39. The Health Visitor did not attend the next LAC review the following April and there is no record of her contributing to the meeting.

40. Therefore, the Investigator is incorrect as the Health Visitor did not provide any information to the LAC review in April.

41. R had a review health assessment at the end of April. At that review R declined to have their weight measured. The assessment recorded information from the dietician's appointment at the beginning of January. At the appointment the dietician noted R had lost weight and would review it in 8 to 12 weeks at a follow up appointment. The review appointment with the dietician should have happened three weeks before the review health assessment. R was not taken to the review appointment and the review health assessment did not discuss the appointment.

42. The Council also carried out R's review health assessments seven weeks late which was fault. Because the Council did not complete the review health assessment in line with statutory timescales it did not receive the information about R's weight loss. It also did not know that R had not been taken to the follow up appointment with the dietician to monitor their weight. Therefore, the Investigator's findings were flawed which was also fault.

43. Mr X states R was caused harm. However, it is not possible from the information available to identify the cause of R's weight loss and there is no evidence showing it was as a result of living with the paternal relative. Professionals raised no other concerns about R during the period they were a looked after child. Therefore, I cannot say the identified faults caused R an injustice or, but for the fault the outcome would have been any different.

44. I have found no evidence to suggest the Council withheld any information about R's health from Mr X once it was aware of it. However, the Investigator's failure to identify the fault during the stage 2 investigation or during the stage 3 panel considerations caused Mr X frustration and the time and trouble bringing his complaint to us.

Agreed actions

45. The Council has agreed to, within one month of the final decision:

- write to Mr X and apologise for frustration and time and trouble caused by the flaw found in the stage 2 investigation around R's weight loss and the Council's failure to carry out R's health assessment in line with statutory timescales.
- provide a reminder to relevant staff about the importance of carrying out health assessments for looked after children in line with the statutory timescales. The Council will provide us with evidence it has carried this out.

Final decision

46. I have completed my investigation. I have found fault leading to injustice and the Council has agreed to my recommendations to remedy the injustice caused by the fault.

Investigator's decision on behalf of the Ombudsman

17 August 2021

Complaint reference:
20 013 881

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Mr B complained the Council wrongly assessed his mother as having 'notional capital' to pay for care following a series of gifts and a property transfer she made between 2014 and 2017. We uphold the complaint, finding the Council has not taken account of relevant matters in its decision. This has caused Mr B distress because of the uncertainty created. The Council accepts these findings and has agreed action to remedy this injustice, including carrying out a review of its decision.

The complaint

1. I have called the complainant 'Mr B'. He complains on his own behalf and that of his mother 'Mrs C'. He complains that in assessing whether Mrs C should contribute to the cost of residential care, the Council has wrongly assessed Mrs C as having 'notional capital' available to her. In other words, the Council believes Mrs C has intentionally deprived herself of money or other assets to avoid care charges and the Council should include the value of those assets in its financial assessment. This is further to various gifts Mrs C made of money or property between 2014 and 2017.
2. Mr B says as a result the Council is unreasonably expecting Mrs C to pay towards her care based on the value of these assets.

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 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. 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)***

How I considered this complaint

7. Before issuing this decision statement I considered:

- Mr B's written complaint to the Ombudsman and supporting information provided in a telephone conversation;
- information provided by the Council in reply to our enquiries;
- relevant law and guidance as referred to in the text below.

8. I also gave Mr B and the Council chance to comment on a draft decision statement. I took account of any comments made before issuing this final decision.

What I found

Relevant Law and Guidance

9. Section 14 of the Care Act 2014 allows councils to charge for care and support services they provide or arrange. Charges are means tested based on a person's financial resources; including any income or capital they have. Capital includes such matters as savings, investments and can include the value of assets such as houses.

10. The Care and Support (Charging and Assessment of Resources) Regulations 2014 say that "*an adult is to be treated as possessing capital of which the adult has deprived themselves for the purpose of decreasing the amount they may be liable to pay towards the cost of meeting their needs for care and support, or their needs for support*". In these circumstances the Council is to treat the adult 'as if' they still own the income they have deprived themselves of and to treat that as 'notional capital'.

11. The Government has also produced statutory care and support guidance in support of the above Regulations. Annex E of that guidance discusses "*deprivation of assets*". It says a council should refer to the guidance in cases where it suspects somebody has deprived themselves of capital to decrease the amount they are charged for care.

12. The guidance says:

- deprivation may come to light when a council completes a financial assessment with a client. Authorities must *"treat this issue with sensitivity and care"* (paragraph 3);
- people are entitled to *"spend the money they have saved as they wish – it is their money after all"* (paragraph 4). So, "*deprivation should not be automatically assumed. There may be valid reasons why someone no longer has an asset and a local authority should ensure it fully explores this first."* (paragraph 5)
- The term 'deprivation of assets' refers to when a person has intentionally deprived or decreased their overall assets to reduce the amount they are charged towards their care. This means that they "*must have known that they needed care and support and have reduced their assets in order to reduce the*

contribution they are asked to make towards the cost of that care and support" (paragraph 6).

- *"There may be many reasons for a person depriving themselves of an asset. A local authority should therefore consider the following before deciding whether deprivation for the purpose of avoiding care and support charges has occurred:*

a) *whether avoiding the care and support charge was a significant motivation in 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?*

b) *did the person have a reasonable expectation of needing to contribute to the cost of their eligible care needs*?" (paragraph 11)

Chronology of key facts

13. Mrs C first came to the attention of the Council's adult social care service in April 2012. At that time, her husband, who I will refer to as 'Mr C', was still alive but seriously ill in hospital and he passed away the following month. Mr C expressed concern for Mrs C's welfare. Mrs C was known to suffer from asthma and MS. She was said to be struggling with the stairs and showering in the family home. The Council assessed Mrs C but decided her needs did not meet the threshold where she was entitled to receive social care. It suggested she may benefit from some support with tasks such as shopping and cleaning from a charity and signposted accordingly.

14. In March 2013 Mrs C moved to a flat in a retirement complex. She rented this out, wanting to see if she enjoyed living there. She rented the family home.

15. Sometime during 2014 Mrs C gave Mr B's brother (who I will call Mr D) £15,000. Mrs C said in 2017 (see below) this was to support Mr D with his business. Mr B has advised Mr D's business was struggling at the time.

16. In November 2014 Mrs C received some short-term care at home from the Council following a stay in hospital. This ended the following month. She did not have to pay for that care.

17. Around the same time Mrs C received notice that she needed to vacate her rented flat. In January 2015 Mrs C moved to another flat in the retirement complex. This was bought for her by Mr B and his wife, who I will call "Mrs B", with their savings. Mrs C lived there rent free paying the service charge and for utilities and so on.

18. In July 2015 Mrs C transferred the ownership of the family home to Mr B and Mr D (Mr B says the Council has wrongly recorded this transfer in its records as taking place in November 2015). The Council says this was for a value of £110,000. It has been repeatedly recorded that Mrs C did this in recognition that Mr B and his wife had purchased her retirement flat. Mr B said that he asked the transfer include Mr D also even though he did not contribute funds to the flat purchase.

19. In September 2015 Mrs C had another stay in hospital. The Council did not assess she had any care needs on discharge. It says that it has a record that Mrs C was given a booklet on 'paying for care' at this time.

20. In March 2017 Mrs C gifted £12,000 to two daughters of Mr C (Mr B's half-siblings). She did this after receiving a pension lump sum payable in the name of Mr C. Mr B says this was in accord with Mr C's wishes before he died.

21. In April 2017 Mrs C then gifted approximately a further £30,000 to Mr B and Mr D and a grand-daughter. This was after an ISA matured. Mr B says the funds given to him and his brother were in recognition of money spent renovating and improving Mrs C's flat after she moved in. Mr B says he and his brother gave most of this money back to their mother.

22. In April 2017 Mrs C had another stay in hospital. It is recorded in the case notes that she was suffering with COPD (Chronic Obstructive Pulmonary Disease). On discharge she received some care arranged and paid for by the Council. At this point it was envisaged Mrs C would need care at home on a longer term basis.

23. The Council therefore completed a financial assessment to see what Mrs C should contribute towards her care. It was during this assessment the three gifts of money I have referred to above and the house transfer came to light. The financial assessment records that Mrs C gave money to Mr D in 2014 to help with his business. There is no record of her providing or being asked reasons for the other gifts. It is noted on the form that Mr B owned Mrs C's flat.

24. The Council decided all the gifts above should be treated as 'notional capital' and so Mrs C was charged for home care from late May 2017 onward. The Council says Mr B did challenge this decision at the time. When he did so, it says that it asked him to provide a copy of Mr C's will but that he failed to do so.

25. In July 2018 Mrs C was again admitted to hospital. She was suffering from confusion and hallucinations. Mrs C returned home but the symptoms recurred in September 2018. Mrs C entered residential care around this time, initially on a short-term basis but later as a permanent resident.

26. In November 2018 the Council therefore undertook a second financial assessment. As before the Council identified the three gifts of money and the house transfer described above. It again decided to treat these as notional capital. Additional detail contained in this assessment (which was completed with Mr B as he was now Mrs C's attorney) refer to Mr B and Mr D supporting Mrs C with improvements and redecoration to her flat.

27. In December 2018 the Council sent a letter confirming the outcome of its financial assessment. It said it had assessed Mrs C as having around £51,000 in notional capital resulting from the three cash gifts explained above and £153,000 in notional capital from the transfer of her house to Mr B and Mr D. The letter said that at the time Mrs C transferred the house, it was unsuitable for her given her health needs, therefore she *"would have been aware that [she] may need to make financial provision for future care"*. The house valuation was based on information on the website 'Zoopla'.

Mr B's complaint

28. Mr B engaged the services of a solicitor to try and challenge the Council's financial assessment. They complained the Council:

- had put forward no evidence which showed Mrs C had gifted or transferred assets to avoid care fees;
- that all sums gifted or transferred had pre-dated the Council carrying out a financial assessment;
- that most of the sums gifted and the transfer pre-dated a time when Mrs C needed any social care and she had no reasonable expectation of needing residential care;

- that gifts were made to help Mr D with his business at a time of difficulty; to respect the wishes of Mr C or to recognise that Mr B and Mrs B had purchased her flat.

29. In its reply the Council stressed that Government guidance allowed it to consider the timing of a disposal and whether someone had a *"reasonable expectation of needing to contribute"* towards their care needs when they made a gift. The Council suggested that all the gifts, except that made in 2014, were made *"at or around the same time"* that Mrs C began needing care and support. The letter set out some details of Mrs C's engagement with adult social care services since 2012. Also, that Mrs C had received Attendance Allowance for some years. The Council said it would make some adjustment to the notional capital amount to take account that money was spent making Mrs C comfortable in her flat.

30. Mr B's solicitor asked for copies of the care records the Council referred to in its response. It did not provide these for several months. But by August 2020 the solicitor had received and reviewed the files. It said:

- these did not show Mrs C had a reasonable expectation of needing care and support at the time of making any gifts;
- that Mrs C's asthma and MS were always mild and a letter dated June 2020 from a health practitioner confirmed this was still the case; Mrs C entered residential care because of a previously unknown mental health illness whose symptoms only presented from July 2018.

31. In November 2020 the Council gave its final reply to the complaint. It said that it believed it had addressed all the issues raised by Mr B and followed 'due process' in its decision making. The Council therefore signposted Mr B to this office if he remained dissatisfied.

My findings

Ombudsman's jurisdiction

32. I note the financial assessment being challenged by Mr B is that completed by the Council in December 2018. More than 12 months elapsed between Mr B receiving that assessment and complaining to the Ombudsman. This makes Mr B's complaint a late complaint.

33. However, I consider there are special reasons that justify investigation. Within 12 months of the assessment Mr B engaged a solicitor who then raised a complaint on his behalf. Over 12 months passed between the solicitor's first letter and the Council's final response. However, I do not find Mr B contributed significantly to that delay. I find the biggest source of delay in the complaint procedure completing was that Mr B and his solicitor were waiting several months for care records. They considered these important as the Council referred to those records in justifying its position. I think it reasonable Mr B would want to read the records before deciding whether to pursue the complaint.

34. I am conscious that only part of the financial assessment in December 2018 was new – that part which related to the transfer of property between Mrs C and Mr B (and Mr D). In its financial assessment in May 2017 the Council decided to treat three cash transfers made by Mrs C between 2014 and 2017 as 'notional capital'. It took the same approach towards those transfers in its December 2018 assessment. I have considered therefore if Mr B's complaint about the treatment of the cash transfers should be considered as out of time, leaving this investigation to focus only on the treatment of the house transfer.

35. However, I do not think this would be a fair approach to take. First, because in its correspondence since December 2018 the Council has not sought to draw any such distinction. Indeed, it has implied that it may take a slightly different view of two of the transfers now than it did in May 2017. It would not be appropriate therefore not to investigate the Council's own reconsideration of this matter.

36. Second, because the assessment has a lasting and ongoing impact in terms of what the Council expects Mrs C to pay towards her care.

37. However, I take the view that any findings made in this case should only apply to the December 2018 assessment. As Mr B only engaged the Council's complaint procedure further to that assessment and not in response to the May 2017 assessment.

On the substance of the complaint

38. Turning in detail to the December 2018 assessment, I set out above relevant Government guidance which instructs councils on what to do if they believe someone may have deprived themselves of an asset to avoid care charges. I consider the following general statements can be made:

- that identifying there has been the gifting of an asset, regardless of timing, is not enough to show the gift was made to avoid care charges;
- that the Council must be able to show or reasonably infer on the facts there was *intent* to avoid care charges as a motivating factor behind a gift;
- to reach a decision on this question, the Council can legitimately make enquiries about assets which are disposed of but must do so with sensitivity;
- this means in turn, the Council must consider the reasons put forward for a gift being made; the Council can consider whatever evidence there is to support the reasons put forward;
- it is relevant to consider whether someone had a reasonable expectation of the need for care and support at the time they made a gift;
- also, the Council must consider if the person had a reasonable expectation they may have to pay for such care; as the timing of a gift can be relevant when weighing evidence as to whether there was any intent to avoid care charges.

39. In considering whether the Council made a decision in line with all the guidance above, I note the Council has cited:

- that Mrs C had health problems since 2012 and was known to social care from this time; she was at that time not found to meet the threshold for social care but was having some difficulties managing her home due to health and age-related issues;
- that Mrs C had further discussions with the Council about her health and/or care needs before May 2017; the Council has a record that at least in general terms Mrs C received some information about circumstances where someone may have to pay for care;
- that in the two months before Mrs C was assessed as having social care needs in May 2017 she had gifted over £40,000 in two separate sets of transactions to family members.

40. I also note that nowhere have I seen put forward an explanation for Mrs C's gift in April 2017 to a grand-daughter.

41. I consider all the factors listed in paragraph 39 and 40 potentially relevant to a decision on whether the Council should treat Mrs C as having notional capital after depriving herself of assets. There is no fault in the Council considering the relevance of these matters.

42. However, I cannot see where the Council has also addressed itself to the following considerations:

- that an explanation has been put forward for why Mrs C gifted £15,000 to Mr D in 2014 for reasons other than to reduce the level of care charges she should pay; that he needed support with his business at the time; this gift was at a time when Mrs C did not have any assessed social care needs; in its complaint response the Council indicated it may no longer consider Mrs C has notional capital as a result of making this gift but I have not seen this clarified or confirmed;
- that an explanation has been put forward for why Mrs C gifted £12,000 to Mr C's daughters in March 2017 for reasons other than to reduce the level of care charges she should pay; the Council's decision and complaint replies do not refer to whether it accepts this explanation and if not, why not or what evidence it might need to be persuaded otherwise;
- that an explanation has been put forward for why Mrs C gifted some of the £30,000 in April 2017 to Mr B and Mr D in recognition of money they spent on her flat; the Council's response to the complaint implies it might now accept some of this explanation but it has not clarified this; nor what difference this makes to its assessment;
- that an explanation has been put forward for why Mrs C gifted her home to Mr B and Mr D for reasons other than to reduce the level of care charges she should pay; Mr B says this was in return for Mr and Mrs B buying her retirement flat; the Council's decision and complaint response does not refer to whether it accepts this explanation and if not, why not.

43. I consider part of this failure results from the Council not following a sufficiently robust process in gathering information necessary to make an administratively sound decision. It has given the impression of jumping to a conclusion about the money gifted by Mrs C and the transfer of property, without first exploring the transactions individually.

44. The failure to consider the series of relevant factors listed in paragraph 41 means the Council is at fault. The Council cannot pick and choose which facts it finds most convenient in support of its decision. Nor can it pick and choose which parts of the statutory guidance it finds most convenient. The Council must make a robust decision that shows it has properly considered all the facts and all the relevant guidance. It has not done so here.

45. This has caused an injustice. I cannot say whether an administratively sound decision would come to the same outcome, a very different outcome or produce an outcome which may go only slightly to Mrs C's favour. I reiterate that I do not find the Council has put forward considerations without merit. But it has not balanced those with other relevant considerations. I find significant uncertainty results therefore from the administratively unsound decision taken by the Council. We regard this as a form of distress. I also find this has caused Mr B unnecessary time and trouble in pursuing complaint about this matter.

Agreed action

46. The Council accepts these findings. To remedy the injustice set out at paragraph 45 it has agreed that within 20 working days of this decision, it will:

- apologise to Mr B accepting the findings of this investigation;
- pay Mr B £250 in recognition of his time and trouble;
- agree to a reassessment of its decision that Mrs C holds 'notional capital' in line with the advice set out at paragraph 46 below.

47. The reassessment will be completed by an officer who has had no previous involvement in Mrs C's case. The Council will aim to complete the assessment within three months, enabling it to ask any relevant questions of Mr B and/or ask for any supporting evidence it thinks might be helpful to its decision. It will make relevant enquiries in writing and ask for replies in writing so there is an audit trail in support of its decision. It will offer Mr B signposting in the event he is dissatisfied with its reassessment. This can include signposting Mr B direct to this office if the Council sees no merit in further consideration of a complaint via its own procedure.

48. In addition, within three months of a decision on this complaint the Council will issue a briefing to all staff who make financial assessments to remind them of the requirements necessary to make a robust decision when it suspects someone has 'notional capital' resulting from deprivation. This can be in the form of a written reminder, staff briefing or training as it considers appropriate. The Council will write to us and tell us what action it has taken here.

Final decision

49. For reasons set out above I uphold this complaint finding fault by the Council causing injustice. The Council accepts this finding and has agreed action I consider will remedy that injustice. I have therefore completed my investigation satisfied with its response.

Investigator's decision on behalf of the Ombudsman

23 August 2021

Complaint reference:
20 009 398

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Mr and Mrs X complained about poor transition planning for their daughter, Miss Y, when she moved from children's to adult support services, including the withdrawal of support services. The Council was at fault for its inconsistent communication about whether it would extend the overnight stays arranged by children's services beyond age 18, and for flaws in its complaints handling. The Council took appropriate steps to identify support for the family during the COVID-19 pandemic.

The complaint

1. Mr and Mrs X complained about the poor transition planning for their daughter, Miss Y, from children's to adult services when she reached age 18 in December 2020. They said Miss Y received no support after turning 18 and were particularly unhappy that respite support care was withdrawn, which placed a significant strain on Mrs X, who is Miss Y's main carer.
2. Mr and Mrs X also complained about the Council's complaints handling, which split the complaint between the two services despite it being about transition between them. This caused delay and mis-communication, putting them to extra time and trouble pursuing the Council.

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. This complaint involves events that occurred during the COVID-19 pandemic. The Government introduced a range of new and frequently updated rules and guidance during this time. We can consider whether the council followed the relevant legislation, guidance and our published "Good Administrative Practice during the response to COVID-19".

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)***

How I considered this complaint

7. I considered:

- the information provided by Mr and Mrs X, and spoke to them by telephone;
- the information provided by the Council in response to my enquiries;
- relevant law and guidance, as set out below; and
- our guidance on remedies.

8. Mr and Mrs X and the Council had an opportunity to comment on my draft decision and I considered their comments before making a final decision.

What I found

Relevant law and guidance

Education Health and Care (EHC) plans

9. A child or young person with special educational needs may have an Education, Health and Care (EHC) plan. This sets out their needs and what arrangements should be made to meet them. An EHC plan should be reviewed annually and may continue until the young person is aged 25 years. The Council is responsible for ensuring the support arrangements set out in the EHC plan are delivered.

10. Under the Coronavirus Act 2020 the Secretary of State issued a notice that temporarily modified the absolute duty to secure or arrange educational provision set out in an EHC plan so that from 1 May to 31 July 2020, councils had a duty to use their "*reasonable endeavours*" to do so.

Chronically Sick and Disabled Persons Act 1970

11. Section 2 of this Act sets out the services councils must make available to parents of disabled children. This includes short breaks and respite care. Short breaks can take many forms, including access to play schemes. Where a short break cannot take place at the child or young person's home or in a community-based setting until the 1970 Act, the council can provide services under section 17 of the Children Act 1989.

Children Act 1989

12. Section 17 of this Act says a child or young person is "*in need*" if they are disabled. Councils have a duty to assess the need and provide appropriate services to meet the assessed needs.

CAMHS

13. Children and Adolescent Mental Health Services (CAMHS) is a health service for children and their families, who need support for mental health issues and learning development issues.

Direct payments

14. Where there is a need for care and support for disabled children and young adults, the Council can provide or commission services to provide the support or it can make direct payments to the family so they can arrange care and support themselves.

Transition from children's services to adult social care

15. When a child reaches age 18, they are legally an adult and responsibility for meeting their needs moves from the council's children services to its adult services. The legal basis for assessing their needs changes from the Children Act 1989 to the Care Act 2014. However, councils can decide to treat a children's assessment as an adult assessment and can also carry out joint assessments.

16. Statutory guidance says transition assessments should begin when the council can be reasonably confident about what the young person's needs for care and support will look like when they turn 18. The purpose of the assessment is to provide the young person and their family with information so they know what to expect in future and can prepare for adulthood.

17. The assessment must identify all the young person's needs for care and support, and should identify the outcomes the young person wishes to achieve. The assessment should also consider whether the carer is able to continue in their caring role after the young person turns 18.

18. After completing the transition assessment, the council must give an indication of which of their needs are likely to be "*eligible needs*" under the Care Act 2014, and which are not. This is so they and their carers can understand the care and support they are likely to receive and can plan accordingly. For those needs that are not "*eligible*" the council must provide information and advice on how those needs can be met.

19. If transition assessment and planning is carried out effectively there should be no gaps in the provision of care and support. However, if adult care and support is not in place when the young person turns 18, the council must continue providing the services under children's legislation until it is in place or until it decides the young person does not have "*eligible needs*". ***(Care and Support Statutory Guidance, 2014, at paragraph 16.68)***

20. For young people with complex needs, the council may decide that children's services are the best way to meet their needs even after they have turned 18, and the law allows them to do this.

Children's statutory complaints process

21. The law sets out a three stage procedure for councils to follow when looking at complaints about children's social care services. The Council should respond to the complaint at stage 1 within 10 working days. At stage 2, the Council appoints an investigating officer to investigate the complaint, and an independent person, who is responsible for overseeing the investigation. Stage 2 should take 25 working days, with a maximum extension to 65 days. If the complainant remains unhappy they can ask for a stage 3 panel or refer the matter to us.

22. The Guidance: Getting the best from complaints at paragraph 7.8.1 says where there are related complaints that do not fall within the statutory procedure, councils may wish to consider whether there are advantages in accepting these into a single investigation. Further, paragraph 7.8.2 says councils are "*encouraged to offer a complete single response where possible*". Staff should agree who will take the lead, and they will liaise with other staff as needed and, where possible, provide a single reply that covers all aspects of the complaint.

What happened

23. Mr and Mrs X live with their daughter, Miss Y, who has SEN. She had an EHC plan and a package of support from children's social care. Miss Y needs a high level of care and support, and her behaviour can be challenging, particularly when

her routine is disrupted. The Council initially contacted Mr and Mrs X about planning for the transition from children's to adults' services in December 2019, a year before she turned 18 in December 2020.

24. The records show the Council carried out an assessment of Miss Y's needs, which it completed in early February 2020. It asked officer 1 to oversee the transition to adult services. Officer 1 met with Mrs X regularly from mid March to discuss the support arrangements for Miss Y as an adult. She also met Miss Y at her school, to discuss her wishes and feelings.

25. At the first home visit, in March 2020, Mrs X said she was concerned that services would change when Miss Y was 18. At this point, Miss Y was supported through:

- 48 over night short breaks per year with provider A;
- a session on alternative Saturdays run by charity B, funded using direct payments;
- 60 hours of individual support through the same charity, also paid for with direct payments; and
- 140 hours funded at a holiday club at school.

26. In the mid March 2020 visit, Officer 1 explained the support from children's services would stop when Miss Y was 18 and be replaced with support arranged by adult services to meet her eligible needs, as set out in the assessment finalised in early February. Officer 1 said the support may take different forms because there were no adult alternatives to some services, such as the holiday club, and some items currently funded by direct payments would need to be funded using Miss Y's benefits. Officer 1 encouraged Mrs X to visit three Council run respite providers for adults that could potentially offer overnight stays for Miss Y. The record shows Mrs X was reluctant to do so. (Mrs X told me she had already done some research of her own about possible providers). She said she had had a negative experience with one of the providers and she felt the other two were too far from their home. She said she preferred provider C, a private provider that was closer to the family home. Provider C was also the educational setting Miss Y hoped to attend from September 2021.

27. After the meeting, officer 1:

- discussed the case with their manager, who agreed to request approval for funding overnight respite from the private sector;
- contacted charity B, which confirmed it could continue to support Miss Y after she turned 18.
- confirmed to Mrs X the Council would carry out a carer's assessment and booked a home visit to discuss her caring role. In the event, a home visit was not possible due to the COVID-19 pandemic so, to avoid delay, officer 1 sent a blank form to Mrs X to add her views.

28. Also, in March 2020, Mrs X said she had a conversation with provider A about extending the overnight stays after Miss Y turned 18 and understood this was agreed in principle.

29. In late March, the Government announced a national lockdown. Due to the risks of COVID-19 for Miss Y, her parents decided she should stay at home. In early April 2020, Mrs X reported Miss Y's behaviour was becoming difficult, due to her disrupted routines. In response, the Council:

- provided some resources to help Miss Y understand what was happening;

- agreed provider A would provide overnight stays to support the family, following Mrs X's contact with provider A. These continued from May 2020, although some stays were cancelled due to the COVID-19 pandemic and the overall level of provision was significantly reduced;
- offered to look at additional support in the home, which Mrs X declined as she did not feel this would work due to Miss Y's routines;
- carried out regular welfare checks by telephone.

In addition, provider A made regular welfare checks and gave Mrs X advice about managing Miss Y's behaviour.

30. In early May 2020, Miss Y returned to school on a part time basis, two days per week. There were also discussions about Miss Y moving to the adult group with charity B, which Mrs X declined, and charity B later agreed Miss Y could continue in the current group beyond 18. Also in May, officer 1 offered a virtual tour with provider C, which Mrs X declined because she did not think Miss Y engage with it.

31. In mid June 2020, Mrs X reported during a welfare check that:

- Miss Y was doing well and still attending school two days per week;
- the individual support from charity B had stopped and Miss Y was missing it; and
- she still did not consider that extra support in the home would work.

Mrs X asked about holiday clubs but the Council was not able to say if they would be running due to COVID-19 restrictions.

32. In early July 2020, Mrs X reported during a welfare check that Miss Y was enjoying school twice a week and various other activities and outings on other days. In mid July, Mrs X reported to officer 1 and provider A that Miss Y's behaviour been escalating from some time.

33. Also, in July 2020, Council records indicate it told Mr and Mrs X it would not agree to an extension of short break respite support from provider A after Miss Y was 18. It said this was because the focus should be on finding alternative provision from adult services. It also said, providers, including provider C, were starting to reopen after the COVID-19 restrictions were relaxed and beginning to take on new referrals.

34. In mid August, Mrs X reported to provider A that the family holiday had been difficult due to Miss Y's behaviour and she "did not know how much longer she could cope". Provider A suggested she might want to consider supported living but Mrs X said she was afraid this would mean she would lose her daughter.

35. Attempts to identify private providers in July and August were unsuccessful because no providers made bids. This was due to COVID-19 restrictions which reduced the services available and the various changes in restrictions made it difficult for them to plan for future services. In mid August, officer 1 said if there were no providers interested by late August the Council would again discuss "our contingency plan" of extending provider A support.

36. In late August, the Council's record indicates Mrs X reported:

- Miss Y was physically abusive to both parents;
- the individual support through charity B had stopped as the staff member could not continue providing the service;

- Miss Y would soon be 18, at which point the current support package would stop and Mrs X was unsure what support Miss Y will transition to;
- the family were unhappy that their request for a three month extension to overnight respite at provider A after Miss Y turned 18 had been refused;
- an application had been made for a college place for September 2021 but this would be for three days per week, and support would be needed for the other two days;
- the family had no support network and were now in crisis.

37. In light of the family situation, a referral was made to CAMHS for support with Miss Y's behavioural issues, and to its children's disability service, for a fresh assessment. CAMHS later assisted with a behavioural support plan. The children's disability service carried out a reassessment but the Council's panel decided Miss Y did not meet the threshold for additional services.

38. In early September, after a period of not accepting new referrals as a result of the COVID-19 pandemic, two of the Council's internal providers began to accept them and the Council asked Mrs X to consider these. It also offered her support to explore the possibility of a shared lives arrangement and encouraged her to consider other forms of support until overnight respite could be found.

39. At a home visit in mid September, Mrs X reported a further decline in Miss Y's moods and behaviours, which presented a high risk to herself and others. Mrs X and officer 1 discussed proposals for support, including:

- Home based support to give Mrs X a break from her caring role. This was not considered beneficial at that time.
- The staff member providing individual support through charity B could not continue. This service was funded through direct payments and Mrs X would contact the charity to see if they could identify a personal assistant to support Miss Y.
- Continuation of the children's support group beyond Miss Y's 18th birthday.
- Asking Mrs X to reconsider the Council's internal short breaks service.
- Officer 1 agreed to ask if support from provider A could be extended, since no progress had been made in identifying overnight respite provision. The Council said later in September this would not be considered until the family had explored other options, including support from its internal providers.

40. Miss Y was seen at school in mid September by officer 2, the social worker carrying out a reassessment for the disabled children's team. The school did not report any behavioural issues but were aware of concerns about physically aggressive behaviour at home. Following the school visit, officer 2 spoke to Mrs X at home.

41. In early October provider C started taking referrals for overnight respite stays. Mrs X completed an application and an assessment session was booked for half term week. In mid October, the Council advised care provider E (which Mrs X says she initially identified for possible support when Miss Y was not in school or college) was taking new referrals.

42. Also in early October 2020, officer 1 discussed the following with Mrs X as part of a home visit:

- Provider A was no longer allowing extensions beyond age 18 for any clients. Officer 1 had asked provider A to explain its position to Mrs X.
- Shared lives arrangements but Mrs X did not consider this was suitable for Miss Y as she needed peer interaction.
- Possible support from an autism charity.
- Home based care and support, which Mrs X refused because she said Miss Y had a well-established routine after school and support in the evenings would not be beneficial as Miss X would be too tired.
- Mrs X had not identified a personal assistant and officer 1 gave advice on where to advertise for one.

43. Two days later, officer 2 spoke to Mrs X about Miss Y's support package. She said she would discuss the proposed extension of support by provider A but there needed to be a clear plan for support when that ended. Officer 2 advised Mrs X to engage with adult services and be open to their suggestions.

44. Mr and Mrs X were unhappy with the decision that overnight stays could not be extended for three months as requested and made a formal complaint. Officer 1's manager, officer 3, responded to their concerns. The response indicated the Council may consider the extension requested but that the family also needed to explore other adult service options, which were set out in detail. Provider A later agreed to a one month extension to late December 2020 but Mr and Mrs X remained unhappy as they said they had previously been told a three month extension was agreed.

45. There were further discussions at a home visit in early November, by which point provider C had offered Miss Y a provisional place from September 2021 (the next academic year). Mrs X was considering short breaks with provider D, one of the Council's internal providers for adults and had visited, although she said it took 45 minutes to get there. In light of this, Mrs X felt it would be more suitable when Miss Y was in college. Provider C was still the family's preferred service. Mrs X reported she had cancelled the Saturday sessions with charity B due to the risk of COVID-19. The record says Miss Y's support plan was discussed and officer 1 explained this would be developed further over the coming weeks.

46. In mid November, there was an online meeting to discuss the refusal to extend the provision with provider A for three months. The record shows Mr & Mrs X:

- expressed frustration that the complaints responses were by email and managers had not tried to speak to them by telephone;
- said they did not consider the options suggested met Miss Y's needs; and
- maintained a three month extension with provider A was the best option for Miss Y.

The record shows the Council:

- said it had agreed an extension for one month and explained why it could not agree a further extension; and
- explained the support available and suggested they met with officer 1 to discuss that in more detail and finalise the support plan.

Mr X said the meeting was a disgrace and no-one was listening to them. He says the Council did not explain why it could not agree to an extension.

47. Following the meeting, the Council wrote to set out what had been discussed and answer some questions Mr and Mrs X had raised, which had not been addressed during the meeting due to a lack of time. Mr and Mrs X remained unhappy. However, the Council refused to consider the complaint further at stage 2 of its complaints process because that could not achieve the outcome they wanted, namely for the Council to reverse its decision about the extension. It said it would respond separately to concerns they raised about adult services.

48. Officer 1 moved to a new role in late December 2020. In mid December, she held a transfer meeting with her manager, officer 3, who took on responsibility for the transition planning from January 2021.

49. Officer 3 had regular discussions with Mrs X about support for Miss Y from January 2021 onwards and the records show she was proactive in considering various ways to support Miss Y and the family, and arranging the funding for support. However, efforts to put the support in place were hampered by further restrictions due to COVID-19 and a third national lockdown. For example, due to COVID-19 restrictions provider D was not able to do the planned taster visit for Miss Y with her mother accompanying her – Miss Y would have had to attend alone, even though she had not been there before or met staff there. In the event, it was decided that due to levels of infection the visit should be postponed. Without taster visits, it was not possible to book overnight stays.

50. In March 2021 Miss Y was able to return to school and the weekend sessions with charity B. There were also visits to providers C, D and E. Following these visits Mrs X was able to book some sessions with providers D and E. However, further discussions with the family's preferred provider, provider C, indicated that it could not meet Miss Y's needs, largely due to changes to its services in response to the COVID-19 pandemic. Mrs X found a personal assistant through charity B in late February, funding arrangements were agreed in March and support began in early April.

51. Therefore, by early May 2021 there were some services in place, although the overnight stays were not at the level provided before Miss Y reached age 18 nor were they at the level Mr and Mrs X felt was appropriate. There are ongoing discussions with the Council about Miss Y's support plan and, in particular, the number of overnight stays.

Complaints handling

52. Mr and Mrs X complained in early October 2020 about the Council's decision not to agree an extension of the overnight stays beyond December 2020. The Council accepted there was some mis-communication about this and apologised in late October 2020. It explained that provider A could not extend further as its services were reduced due to the COVID-19 pandemic.

53. In a further letter in early November 2020, the Council said although it had originally agreed to consider a three month extension, it was important to also consider other options with adult services and that remained its position. In recognition of the family's concerns the provision had been extended by one month but it could not commit to a further extension.

54. Mr and Mrs X remained unhappy with the decision not to extend the provision. The Council arranged an online meeting to discuss their outstanding concerns. At the meeting and subsequently Mr and Mrs X raised concerns about the transition process, poor communication and a failure to identify appropriate adult services

for Miss Y. These issues were considered by the Council using its adult complaints process.

55. Mr and Mrs X remained unhappy with the outcome of that process and were also unhappy that their concerns were considered separately by children's and adults services, particularly given the concerns were about transition between the two.

56. In response to my enquiries, the Council said there was some confusion between the officers involved about what had been agreed about extending the provision with provider A, which was clarified at the complaints meeting and then confirmed in writing. It did not consider it was appropriate to use the statutory children's complaints process because its priority was to get services in place for Miss Y and it did not consider the statutory process could achieve a meaningful outcome in a timely way.

57. The Council said the ongoing concerns raised by Mr and Mrs X were about its preparing for adulthood team, which falls under its adult services and therefore it considered those using its adult services complaints process. Its usual timescale for adult complaints is to respond within 20 working days. It accepts it did not do that on this occasion for which it has already apologised to Mr and Mrs X but is happy to do so again.

58. In terms of the timescales, the Council told Mr and Mrs X on 4 December 2020 it would address the additional concerns using its adult services complaints process. Mr and Mrs X provided further information on 11 and 21 December 2020. The Council prepared a detailed report of its investigation, dated 21 January 2021, and provided a complaint response letter on 2 February 2021.

My findings

Transition

59. The Council contacted the family a year before Miss Y turned 18 to start planning for the transition to adult services. An assessment of her eligible needs was completed in early February 2020 and officer 1 was assigned to work with the family soon after that. I am satisfied the Council began the transition process in good time and was not at fault.

60. The family were receiving a significant package of support for Miss Y through children's services and Mrs X was understandably worried about losing support she relied on when Miss Y turned 18. Officer 1 explained in March 2020 that support may be different once Miss Y was an adult and explained the options available. She suggested visits to Council providers of adult overnight stays but Mrs X did not want to explore these. Mrs X says she had already done her own research before the transition process began. Mrs X's preferred provider was provider C and the Council confirmed funding for private providers without delay. I find not fault with the way the Council handled the transition at this stage.

61. In late March 2020, restrictions in response to the COVID-19 pandemic meant that:

- private care providers were not bidding for services as they had had to reduce the services offered. Provider C did not start taking new referrals until October 2020;
- visits to adult care providers could not take place. Council providers of adult overnight stays could not take new referrals until September 2020;

- provider A continued to offer overnight stays to Miss Y but not at the previous level;
- some services were available but due to the risks of COVID-19, the family felt unable to access them.

62. This caused delay between April and September in identifying adult care services for Miss Y but this was outside the Council's control and was not fault.

63. I understand this period was difficult for the family because Miss Y's behaviour was more difficult to manage due to the disruptions to her routine, and because they had to manage with less support than before. However, the Council did offer support by:

- ensuring as many overnight stays with provider A as possible;
- welfare checks and telephone support;
- considering how direct payments could be used to provide support in the home; and
- referrals to CAMHS and the children's disability team.

I am satisfied the Council took sufficient steps to support the family at this difficult time and was not at fault.

64. From September to December 2020, the Council made little progress in arranging adult services for Miss Y, although officer 1 continued to discuss options with Mrs X and Mrs X did visit provider D. The records suggest both sides became distracted by the dispute over whether provider A could continue to provide overnight stays beyond age 18, which I will discuss below.

65. From January 2021, officer 3 took over the case. Officer 3 discussed the support options with Mrs X and pursued them as best they could. However, once again, COVID-19 restrictions meant progress was slow because services were either not able to offer visits or infection rates were such that it was too risky for Miss Y to attend. I cannot criticise the Council for events outside its control and am satisfied the case was progressed as well as could be expected between January and May 2021.

Requested extension to provider A support

66. The family requested an extension to the overnight stays with provider A at an early stage. Mrs X said this was agreed by provider A in principle in March 2020, but this was a conversation and there was no written record to confirm this.

67. Following the formal complaint in October 2020, the Council accepted there were problems with its communication about this due to confusion between its adults and children's teams about what each had discussed and agreed. The records show that although the Council's position in March was that adult services should be considered before any extension to children's services was discussed, and this remained the position, although its communication about the possible extension was inconsistent. At various points the Council indicated it was considering the three month extension or at least it was there in the background as a contingency.

68. It was not fault for the Council to say it would not consider an extension until the family had explored adult options. Although the family hoped that after the three months' extension services would be available through their preferred provider, provider C, there was never any guarantee that would be the case so it was sensible to consider other options as well. However, it was at fault for not communicating its position clearly and consistently between March and mid

November 2020. It would also have been better if it had been more proactive in addressing the family's concerns about its own adult services but I cannot say this would have changed the family's views and therefore stop short of saying this was further fault.

69. It was not fault for the Council to say it would not consider an extension beyond December 2020, given that provider A's capacity had been significantly reduced as a result of COVID-19 restrictions, other children were waiting for the service for whom no alternative service was available, and adult services were available for Miss Y that the Council considered would meet her needs.

Delivery of support in Miss Y's EHC plans from April 2020

70. Miss Y's EHC plan dated 7 April 2020 set out in section H1 that she had 144 short break hours and 140 holiday club hours. Section H2 set out her 48 overnight stays with provider A. This plan was effective until 11 February 2021 when a final amended EHC plan was issued.

71. The records show that provider A continued to provide overnight stays until late December 2020, although some planned stays were cancelled due to COVID-19 so the family did not get the full 48 overnight stays in that period. In normal circumstances, the provision should have continued until an amended EHC plan was issued in February 2021 because the support and the provider were set out in the April 2020 EHC plan. However, this was not possible due to the impact of the pandemic, as explained above, and since it resulted from factors largely outside the Council's control I have not found fault with the Council.

72. The records also show that other services Miss Y had previously used were not always available to her during this period and that where services were available she did not always attend them because of the COVID-19 risks. Again, I cannot say this was fault by the Council. I am satisfied the Council did what it reasonably could to ensure support was provided.

73. The amended EHC plan issued in February 2021 did not include any information about social care support in sections H1 and H2. The family say they did not accept that plan and a revised plan was issued, which included the same social care support as before. However, it was not possible by then for the support from Provider A to be delivered for the reasons discussed above and there is nothing more I could achieve by pursuing this further.

Complaints handling

74. I consider the complaint about refusing to extend the provision with provider A comes within the scope of the statutory children's complaints process. I have set out the timescales for this at paragraph 21 above.

75. The extension at stage 2 to 65 working days should be in exceptional cases and not the standard timescale. Therefore, I am not persuaded by the argument that it should not be used where a timely outcome is needed, although I do acknowledge there are often delays in the process. I am also not persuaded that the need to prioritise identifying services for Miss Y was a reason not to use the process because it should be possible to continue to provide such services whilst the complaint process is ongoing. Therefore, I consider the failure to consider the complaint using the children's statutory process was fault.

76. Although the Council did not have to use the statutory children's process for the adult services complaints, it should consider providing a single response. I have seen no evidence to show the Council considered this and that was fault.

77. However, I acknowledge the Council did respond to all the complaints raised, including preparing a detailed investigation report on the adult services aspects, although I note Mr and Mrs X remain unhappy with the outcome. Further, the Council did arrange an online meeting to discuss their concerns in November 2020. Therefore, I consider the injustice caused to the family is limited to the uncertainty about whether a different process, combining all the concerns raised, would have delivered a different outcome or a quicker outcome, and the additional frustration and time and trouble caused to them in dealing with several teams (children's services, adults services and the complaints team).

78. The records show Miss Y's needs were met throughout by support services or by her family and I do not consider she suffered an injustice as a result of the faults I have identified. Therefore, I have not recommended a remedy for her.

Agreed action

79. The Council will, within one month of the date of the final decision:

a) apologise to Mr and Mrs X for its

- its failure to deal with the complaint about the refusal of the extension using the children's statutory complaints process; and
- its failure to consider addressing all their complaints within that process.

b) pay them £300 for the uncertainty and frustration caused.

80. The Council will, within three months of the date of the final decision, consider the lessons it could learn from this case in terms of joint working between its children's and adults teams, and how it will ensure that complaints about children's services are considered using the children's statutory process. It will report to us with the outcome of this work.

Final decision

81. I have complete my investigation. I have found fault causing personal injustice. I have recommended action to remedy the injustice caused.

82. 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.

Investigator's decision on behalf of the Ombudsman