27 July 2022

Complaint reference:
21 014 353

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Mr X complained about how the Council carried out child protection enquiries and in particular, about how it communicated with him and his partner. The Council was at fault for failing to provide adequate information at the start of its enquiries and for failing to tell Mr X when it ended its involvement. This caused Mr X avoidable distress for which the Council will apologise and pay him £200. It has already made suitable service improvements.

The complaint

1. Mr X complained about how the Council carried out child protection enquiries into a bruise on his daughter's leg. In particular Mr X is unhappy about how the Council communicated with him and his partner during the enquiries.
2. Mr X said this caused his family significant distress and affected their wellbeing.

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. The Ombudsman investigates complaints about 'maladministration' and 'service failure', which we call 'fault'. We must also consider whether any fault has had an adverse impact on the person making the complaint, which we call 'injustice'. We provide a free service but must use public money carefully. We do not start or may decide not to continue with an investigation if we decide:
   - we could not add to any previous investigation by the organisation, or
   - further investigation would not lead to a different outcome, or
   - we cannot achieve the outcome someone wants, or
   - there is another body better placed to consider this complaint.

   (Local Government Act 1974, section 24A(6))
5. If we are satisfied with an organisation'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)***

6. 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

7. I have considered:

- all the information Mr X provided and discussed the complaint with him;
- the Council's comments about the complaint and the supporting documents it provided; and
- the Council's policies, relevant law and guidance and the Ombudsman's guidance on remedies.

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

What I found

Relevant law and guidance

Statutory Guidance

9. 'Working Together to Safeguard Children' July 2018 ('Working Together 2018'). This is statutory guidance for local authorities and other agencies on how they should work together to assess children's needs and make arrangements for promoting and safeguarding their welfare. It sets out the principles, processes and timescales for carrying out child protection investigations.

10. Anyone who has concerns about a child's welfare should make a referral to children's social care and should do so immediately if there is a concern that the child is suffering significant harm or is likely to do so.

Strategy discussion

11. Whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm, there should be a strategy discussion involving local authority children's social care (including the residential or fostering service, if the child is looked-after), the police, health and other bodies such as the referring agency. This might take the form of a multi-agency meeting or phone calls and more than one discussion may be necessary. A strategy discussion can take place following a referral or at any other time, including during the assessment process and when new information is received on an already open case. A strategy discussion should inform whether the local authority should initiate a Section 47 enquiry in accordance with the 1989 Childrens Act (s47 enquiries).

12. The timescale for the assessment to reach a decision on next steps should be based upon the needs of the individual child and no longer than 45 working days from the point of referral into local authority children's social care.

Section 47 enquiry

13. The Council is responsible for ensuring s47 enquiries are carried out by undertaking or continuing an assessment. Local authority social workers have a statutory duty to lead assessments under section 47 of the 1989 Act. In some cases, children's services will carry out single agency enquiries. In cases where a criminal prosecution is being considered, there will be joint enquiries with the police. If the information gathered under section 47 substantiates concerns and

the child may remain at risk of significant harm, the social worker will arrange a child protection conference within 15 working days of the strategy meeting.

What happened

14. What follows is a brief chronology, in which I have sent out the key events. It is not necessary for me to detail everything that happened here.

15. On 1 July 2021, Mr X's partner noticed a bruise on their daughter, Z's leg. The next day, a health worker saw Z and made a safeguarding referral to the Council.

16. The Council held a safeguarding strategy meeting with the Police. Following this meeting two members of Council staff visited Mr and Mrs X that day. It included Social Worker A, whom Mr X primarily complains about. Later that day a second strategy meeting took place which included discussions with a doctor. The outcome of these discussions was that a child protection medical was needed due to Z's age and the unexplained bruise on her leg. No other concerns were raised.

17. It was agreed Z needed to undergo medical tests the next day. The Council carried out a single section 47 enquiry for the medical tests. It was suggested that Mr and Mrs X would need to find someone to supervise them in Z's presence until Z could have the tests. Social Worker A queried this as there were no concerns about Z's safety around Mr and Mrs X. The Council later decided supervision was not necessary.

18. Mr and Mrs X took Z to the local hospital for tests the next day. A doctor decided that Z needed blood tests. The blood test results returned negative. The hospital decided Z would need more tests.

19. A Council social worker called Mr and Mrs X and told them the results were negative and they would need to find someone to supervise them for the next few days until Z could have further tests. The social worker explained that if Mr and Mrs X could not find someone to supervise them and returned home with Z, the Council could call the Police. Mr and Mrs X said they felt forced to stay in the hospital overnight to wait for the tests because they could not arrange supervision.

20. The tests returned negative, and Mr and Mrs X returned home with Z on 6 July 2021.

21. The next day, Social Worker A visited Mr and Mrs X to explain the next steps. Mr X said he would be recording the visit. The social worker refused, and suggested Mr X could make notes.

22. Social Worker A visited again on 9 July 2021 to carry out an assessment. Mr X said the social worker gave options regarding the second set of tests which suggested they could decide not to have them. Mrs X later tried to cancel the tests, but the hospital said that was not possible.

23. On 21 July 2021 Mrs X informed Social Worker A that she had not taken Z to the second stage of the child protection medical. Mrs X said she did not want her daughter sedated again or without food for several hours. The social worker spoke with the doctor and explained Mrs X's concerns. It was agreed the hospital would attempt to complete the tests without the withdrawal of food and sedating Z. The social worker explained this to Mrs X. Mr X says he questioned the social worker about the information she gave regarding the tests and was told the hospital felt the tests were necessary. Z had the tests that day.

24. Mr X complained to the Council in August 2021. He said:

- they had not received anything to explain the child protection process and were prevented from speaking to a manager;
- staff gave conflicting information, including details about the medical tests;
- it was unfair to require Mr and Mrs X to find someone to supervise them around Z when Social Worker A had been clear they were safe around Z;
- the Council threatened them with Police action to force them to stay in hospital for four days. He said this was not in Z's best interests;
- the assessment report Social Worker A produced was inaccurate; and
- the Council did not tell him or Mrs X the outcome of the case.

25. Mr X also complained about the actions of the hospital including that Z was without food for an extended period, staff were incompetent, and Z was over-sedated.

26. The Council responded to say:

- it was sorry a manager had not spoken to Mr and Mrs X when they requested a conversation;
- there was no evidence that suggested Social Worker A had acted inappropriately towards Mr X or in a discriminatory manner to Mrs X;
- parents are able to record meetings such as the home visit. The Council apologised and said it had raised the issues with Social Worker A;
- it had a leaflet to give to parents which explained the child protection process. Social Worker A was not aware of the leaflet and so had not given it to Mr and Mrs X. The Council said the mistake was not intentional. It also accepted Social Worker A had not told Mr and Mrs X the outcome of the safeguarding enquiries as they should have done. The Council apologised and said it had raised the issues with Social Worker A;
- it had followed the 'Bruising in Pre-Mobile Babies' protocol and followed advice from health professionals;
- it explained to Mr X that the police may be contacted if [they] were to leave hospital with Z without appropriate supervision in place at home. This was to provide Mr and Mrs X with full transparency about the process and procedures in place; and
- it could not change the content of the assessment but would ensure Mr and Mrs X's views on it were recorded'

27. In December 2021 the Council held a meeting with Mr and Mrs X to discuss the complaint. The Council then wrote to Mr and Mrs X and acknowledged it had failed to inform Mr and Mrs X of the outcome of its section 47 enquiries and when it ended its involvement. The Council apologised to Mr and Mrs X.

28. Mr X remained unhappy and complained to the Ombudsman. Mr X told me his main concern was that Social Worker A refused to be recorded. Mr X felt that if he had been able to make recordings, he would have evidence the social worker was unable to do their job. He said his main desired outcome was to have the social worker removed from her role and prevented from doing social work in future.

My assessment

29. I consider the Council's complaint investigation to be comprehensive and thorough. I have not seen evidence that contradicts its findings or indicates further

investigation is necessary. I have therefore focussed my investigation on Mr X's complaint to the Ombudsman about the actions of the Council involving Social Worker A.

30. I have reviewed the recorded events in this case. The documentary evidence shows the Council considered the referral, potential risk to Z and consulted with Health and the Police. This is well documented in the notes of the strategy discussion, outcome of the section 47 enquiries, and case notes. It was due to Z's age and the unexplained bruise on her leg that a child protection medical was required. The Council's Officers are entitled to use their professional judgment and I cannot question the merits of their decision.

The Ombudsman's jurisdiction

31. Mr X complained about the decision to carry out a child protection medical and the tests carried out. Health care and treatment is a matter for health care professionals exercising their professional expertise and judgment. Neither I nor the Council have the authority to judge what tests are suitable for a patient. Further, I have no jurisdiction to investigate the actions of the National Health Service (NHS). The Council is entitled and encouraged to act on the advice of healthcare professionals.

32. The Ombudsman cannot investigate whether social workers are meeting their professional standards of conduct. Complaints of this nature should be referred to the social workers' professional body, Social Work England.

Discrimination during Section 47 enquiries

33. Mr X said his wife was racially discriminated against during the process. The Council has sent me copies of its records on the case, including case notes and records of strategy discussions. There is no evidence to support Mr X's claims of racial discrimination. The documents show Mrs X's views were recorded and taken into account at each stage of the child protection process. I do not find the Council at fault.

Recording meetings

34. Keeping full records of actions on a case is a vital requirement of the enquiry process. It ensures the integrity of information so those involved feel confident their views and experiences have been clearly recorded. I find the Council's records of the home visits are detailed and robust however Mr X was denied the opportunity to record the meetings. This was fault which the Council has accepted, and it caused Mr and Mrs X uncertainty and frustration.

Communication

35. The Council accepted Social Worker A had not given Mr X a leaflet at the beginning of the child protection process or told him when the Council closed the case. The Council said it had addressed that with Social Worker A and assured Mr X the issue was a mistake and not intentional. Mr X disagrees. I have no evidence to suggest the social worker intentionally withheld information from Mr and Mrs X. However, I find the failure to keep Mr and Mrs X well informed throughout the process caused them uncertainty and distress during what was already a difficult time.

The assessment

36. Mr X said the assessment report Social Worker A produced was inaccurate. The Council has addressed this by ensuring a clear record is kept of his views. I do not intend to investigate this part of the complaint further as the Council has

already taken appropriate action to address Mr X's concerns and remedy any injustice.

Medical tests

Mr X says Social Worker A gave conflicting information about the second medical tests which suggested they could decide not to have them. I have reviewed the Council's records and the evidence does not support Mr X's view. To the contrary, the evidence shows the social worker listened to Mrs X's concerns, contacted the hospital and asked whether it was possible to perform the tests without the withdrawal of food and sedating Z. I find no fault by the Council.

Agreed action

37. Where we find an injustice, we try in our remedy proposals to place people in the place they would have been but for the faults. Where that is not possible, we use our Guidance on Remedies which recommends a symbolic payment on a scale of between £100 and £300 in recognition of the injustice caused.

38. To remedy the fault and injustice identified in paragraphs 33 and 34 above, within one month of the date of my final decision, the Council should pay Mr X £200 in recognition of the distress and uncertainty caused by the faults identified.

Final decision

39. I have identified some fault by the Council. I have not identified any other fault and there are some aspects of Mr X's complaint which I cannot investigate. I have recommended action to remedy that injustice. I have completed my investigation on this basis.

Investigator's decision on behalf of the Ombudsman