26 April 2018

Complaint reference:
16 013 319

Complaint against:
Nottinghamshire County Council

Local Government OMBUDSMAN

The Ombudsman's final decision

Summary: The Council failed to ensure an OT assessment was carried out on time and that respite care was provided. This caused injustice to Mr and Mrs D and their son. The Council has agreed to pay monies to be used for F's educational benefit. There is no fault by the Council in refusing to reimburse driving costs or in the provision of social care. Other parts of the complaint are out of the Ombudsman's jurisdiction.

The complaint

1. The complainants, whom I will call Mr and Mrs D, complain through their legal advisor (Mrs M) that the Council has not met their son's needs. In particular they complain the Council:

a) delayed in seeking appropriate Occupational Therapy advice.

b) failed to provide the agreed package of social care.

c) failed to appropriately assess and acknowledge the extent of their son's special educational needs.

d) failed to follow the correct procedure when issuing their son's statement of special educational needs.

e) has not reimbursed driving costs between 23 July 2014 and 15 August 2016.

f) wrongly wanted their son to be considered a Looked After Child under Section 20 of the Children Act 1989.

g) failed to comply with a Subject Access Request within the prescribed time.

h) failed to implement Occupational Therapy recommendations.

i) failed overall to meet their son's needs.

What I have investigated

2. I have investigated Mr and Mrs D's complaints a), b), d), e), and f) above. I explain at the end of this statement why I have not investigated the rest of the complaint.

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

6. The law says we cannot normally investigate a complaint when someone can appeal to a tribunal. However, we may decide to investigate if we consider it would be unreasonable to expect the person to appeal. ***(Local Government Act 1974, section 26(6)(a), as amended)***

7. We cannot investigate a complaint if someone has appealed to a tribunal. ***(Local Government Act 1974, section 26(6)(a), as amended)***

8. SEND is a tribunal that considers special educational needs. ***(The Special Educational Needs and Disability Chamber of the First Tier Tribunal ('SEND'))***

9. We cannot investigate complaints about what happens in schools. ***(Local Government Act 1974, Schedule 5, paragraph 5(b), as amended)***

10. 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)***

11. We may investigate complaints made on behalf of someone else if they have given their consent. ***(Local Government Act 1974, section 26A(1), as amended)***

How I considered this complaint

12. During my investigation I have:

- Spoken with Mrs M about Mr and Mrs D's complaint and considered the supporting evidence they provided.
- Sent enquiries to the Council and considered its responses including information about F.
- Considered legislation and guidance as referenced below.
- Given all parties the opportunity to comment on my draft decision, and issued a second draft decision.

What I found

Relevant legislation and guidance

13. A child with special educational needs (SEN) may have a statement. The statement sets out the child's needs and what arrangements should be made to meet them. The law and guidance governing statements is the Education Act 1996, the 2001 SEN Code of Practice and the SEN Toolkit. The Children and Families Act 2014 replaced statements with Education Health and Care (EHC) Plans. Everyone receiving support will have transferred from the old system to the new by 2018.

14. Parents may appeal to SEND against the provision specified in a statement or EHC Plan, including the named placement, or the failure to name a placement.

15. The Council is responsible for making sure that all the arrangements specified in the statement are put in place. The Ombudsman cannot look at complaints about what is in the statement but can look at other matters, such as where support set out in a statement has not been provided or where there have been delays in the process. The Ombudsman cannot change a statement; only SEND can do that.

What happened

16. The correspondence about this case is detailed and extensive. It is not possible (or necessary) for me to set out everything which has happened. I have set out below the key events.

17. Mr and Mrs D's son, F, was born in 2009. He has been diagnosed with Autistic Spectrum Disorder (ASD). F has significant difficulties due to his ASD including low cognitive function, hyperactivity, high levels of anxiety, and no communication skills. He often demonstrates extreme behaviour including banging his head on walls.

18. In 2013 Mr and Mrs D returned to the UK from overseas. The consultant paediatrician referred F to the NHS Paediatric Occupational Therapy (OT) Service. Following an initial assessment the OT recommended 6 sessions of OT, which F received from early 2014. The Council agreed a package of short breaks to provide respite to the family from November 2013. This was provided by a befriending service using a direct payment.

19. In December 2013 Mr and Mrs D asked the Council to carry out a statutory assessment of F with a view to issuing him with a statement / EHC plan. In April 2014 the short breaks hours were increased.

20. The Council issued F's final statement in April 2014 naming Mr and Mrs D's preferred school (School B). This is a local authority special school for children and young people with ASD. An OT assessment had not been completed but the statement said "F requires urgent assessment by an OT, both functional and sensory" on admission to School B. The covering letter for the statement advised Mr and Mrs D of their right to appeal to SEND. F started at School B in September 2014.

21. Mr and Mrs D told the Council they were struggling to cope. They found the only way to calm F was to drive him around. The Council carried out an initial assessment of F as a child in need. It then increased the hours of short breaks, recommended referral to local support groups for autistic children, a sensory learning and play centre and to purchase a sofa bed and bouncing chair to meet F's sensory needs. Mr and Mrs D disagreed with this and contacted a solicitor (Mrs M).

22. The NHS OT was working with the family and completed a sensory assessment by March 2015. This said F needed "access to linear (forward and backward) movement to help calm him i.e. using a supportive swing or being driven in a car". The consultant wrote to the Council recommending F receive 1 to 1 support. She said F had had little input from the OT service because "the NHS OT only provides for activities of daily living rather than sensory package of care."

23. Mrs M asked the Council to confirm whether F was a child in need. The Council carried out a core assessment in spring 2015. This referred to Mr and Mrs D spending "hours during the day and night, driving for hundreds of miles trying to

calm F and get him to sleep", which Mrs M said they had to do as the Council was not meeting F's sensory needs.

24. The Council responded to Mrs M in June 2015. It said that the NHS OT's assessment "had not been commissioned or agreed by Children's Social Care and therefore Social Care does not have an obligation to fund the costs its recommendations entail. Our assessment is that this practice on a regular basis is dangerous and places both parents and F at risk and therefore the cost of petrol it incurs will not be refunded." The Council proposed alternatives including:

- A review of the current support to see if some of the support offered by the sensory play centre could be moved to the family home.
- Parents to be supported to look at alternative accommodation or to make temporary changes to enable an intensive sleep pattern for F.

25. The Council also agreed to seek an updated assessment from the pilot sensory OT assessment service. This assessed F's functional and sensory needs. It was completed in August 2015. It noted that driving F helped calm him, but said "this is passive input and will not bring about positive psychological change. Active input [such as a large sensory rocker] is more effective." The Council considered a rocking chair would help meet F's sensory needs and noted School B had the environment to provide this.

26. In September 2015 an amended statement was issued. Mr and Mrs D appealed to SEND in November 2015. They wanted the Council to name School C. School C is an independent special school for children with ASD. Mr and Mrs D wanted F to attend School C on a residential basis for 52 weeks a year. They considered F's sensory needs were not being met in School B or outside of normal school hours.

27. The Council considered F was making progress at School B and argued the tribunal should balance the educational benefits of School C against the additional cost of the school to the public purse. In May 2016 SEND found that School B and social care provision could not meet F's needs. It found that only School C could meet his needs. It ordered the Council to name School C in part 4 of F's statement. In July 2016 the Council issued a final amended statement for F naming School C. F started at School C in August 2016.

28. Mr and Mrs D told the Council they intended to pursue judicial review with regard to financial compensation for the driving costs and also reimbursement for petrol costs for visiting F at School C. The Council therefore considered it would be inappropriate to take a complaint through their complaint procedures as some issues were for SEND and there was a possibility of judicial review. In December 2016 Mr and Mrs D complained to the Ombudsman.

Analysis

29. I have considered each of Mr and Mrs D's complaints in turn.

a) The Council delayed in seeking appropriate Occupational Therapy advice.

30. Mrs M complains that F's April 2014 statement said an Occupational Therapy assessment would take place on admission to School B in September 2014, but it was not completed until August 2015.

31. The Council says when F was referred to the NHS OT in 2013 there was a waiting list. The OT's sensory assessment was therefore not completed until spring 2015.

32. The Council did not have any control over the waiting time for an NHS OT assessment. However, it had a duty to ensure the provision in the statement (a sensory and functional OT assessment from September 2014) was delivered and it failed to do this. This is fault.

33. A sensory OT assessment was completed by March 2015. In my first draft decision I found that the delay from September 2014 to March 2015 had not caused significant injustice to F or Mr and Mrs D. This was because the NHS OT was working closely with the family during 2014 and OT sessions were provided. F was attending School B from September 2014 and the Council says at no point did School B advise it could not meet F's needs. The April 2014 statement sets out a variety of provisions to meet F's sensory needs and there is no evidence these were not being provided. In addition I cannot say that the outcome of the sensory assessment would have been any different if it had been completed in September 2014.

34. In response to my draft decision, Mrs M said significant injustice had been caused by the delay because the March 2015 assessment was not sufficient to meet the requirements of the April 2014 statement. I have considered this again. The April 2014 statement required a functional OT assessment as well as a sensory one. The functional element was not completed until August 2015, after the Council had commissioned an updated assessment by the sensory OT service in spring 2015. There was therefore a longer delay of 11 months in meeting the requirement for a functional OT assessment.

35. I have looked at how this affected F and Mrs and Mrs D. I realise Mr and Mrs D say School B was not meeting F's sensory needs. It is not my role to determine whether F's needs were being met. However, I consider the delay in completing the functional OT assessment would have caused uncertainty about whether F was receiving appropriate support between September 2014 and September 2015.

36. The second assessment recommended a minimum of 30 weekly OT session of 45 minutes. This is an increase on what was set out in the April 2014 statement, which required support from an OT. F therefore lost the opportunity of this extra provision.

b) The Council failed to provide the agreed package of social care.

37. F's April 2014 and September 2014 statements say the family should be provided with respite opportunities and that advice should be sought from social services, to determine whether their service has a role supporting the family.

38. The Council then agreed a package of care to meet F's assessed social care needs. This included support from a befriender, which was provided by the sensory play centre. However, this support ended in August 2015 following a dispute about payments. In April 2016 the Council's in-house sitting and befriending team took on the care.

39. I have considered the Council's actions. Between September 2015 and January 2016 it contacted nine possible providers but they did not have capacity or were unable to provide the service required. The Council tried to use its own befriending service, but staff were not available. It provided personal budgets for horse-riding and hydrotherapy sessions.

40. Mrs M says the Council also agreed a personal budget for horse riding therapy for 1 hour per week and an additional hour during school holidays. Mrs M says despite numerous requests, no funds were provided between 20 August 2015

and 1 November 2015. The Council says “numerous attempts” were made to obtain horse-riding sessions but only one could be found before the centres stopped over the winter.

41. The Council assessed and reviewed F’s needs, developed a care plan and made efforts to find suitable providers. When the support provided by the sensory play centre broke down F was left without the full package of care. My initial view was that this did not amount to fault because of the efforts the Council had made to secure provision. Mrs M disagreed. She said the Council had a legal duty to ensure services are provided. I have considered this again. The failure to provide respite care from a befriender service from August 2015 to April 2016 was fault. This caused injustice to Mr and Mrs D as they were without support whilst they were struggling to cope with F’s needs.

d) The Council failed to follow the correct procedure when issuing their son’s statement of special educational needs.

42. Mrs M says Mr and Mrs D’s appeal to SEND was registered on 11 November 2015. But in response to comments from Mr and Mrs D the Council issued a proposed amended statement on 11 November 2015. Mrs M says any amendments should have been made through SEND.

43. In response to my enquiries the Council said Mrs M did not tell it about the appeal until 23 November 2015. SEND told the Council about the appeal on 3 December 2015. There is no evidence of fault.

44. In response to my first draft decision, Mrs M said the Council had delayed issuing the final statement. She said the annual review had been held in March 2015; the final statement was issued on 28 September 2015.

45. The government advice on managing the 2014 changes to the SEN system says councils must give regard to the 2001 SEN Code of Practice for those with statements. The Code does not set timescales for issuing a proposed amended statement following an annual review. It says councils “must make that amendment within eight weeks of sending the amendment notice to the parents.”

46. Following the March 2015 annual review the Council sent Mr and Mrs D a proposed amended statement on 22 July 2015. This was not fault. It then issued the final statement on 28 September. This was nine weeks later which is a delay of one week. I do not consider this caused significant injustice.

e) The Council has not reimbursed driving costs between 23 July 2014 and 15 August 2016.

47. Mrs M says F’s sensory needs were not being met. She says because of a lack of space in the family home for a swing, the only way to calm him was for his parents to drive him for long distances, approximately 820 miles per week. Mrs M complains the Council has refused to reimburse the costs of this.

48. F’s statements identify his sensory needs and say that until these “are addressed, he will not be able to learn.”

49. I asked the Council how it ensured F’s sensory needs were being met. It said F was attending School B, which is the “recognised specialist school in Nottinghamshire with a specialist knowledge and integral sensory based curriculum for children and young people with ASD and sensory needs.” It said at no point did School B say it could not meet F’s needs. The Council said it provided Mr and Mrs D with a Personal Budget to access a specialist sensory short break provider. It had also offered to support Mr and Mrs D with a move to a

different property so F could access “space and sensory equipment outside of school”.

50. The Ombudsman cannot say what F’s needs are or how they should be met. The role of the Ombudsman is to consider if the Council delivered the content of F’s statement.

51. Although the OT’s sensory assessment in March 2015 had acknowledged driving calmed F, the Council had said it disagreed with this as a suitable way to meet F’s needs. F’s statement does not say he needs to be driven. The statement instead contains a number of general provisions to meet his sensory needs and the Council has explained how these were met. There was therefore no duty on the Council to provide for F to be driven or to fund this. I do not find fault with the Council for refusing to reimburse Mr and Mrs D’s driving costs.

52. I realise Mr and Mrs D disagreed with the content of the statement, but this is not something I can consider. This is because the content of statement could be (and was) appealed to SEND.

f) The Council wanted their son (F) to be considered a Looked After Child under Section 20 of the Children Act 1989.

53. On 12 August 2016 (the Friday before F was due to start at School C) the Council emailed Mrs M. The email said “it is the local authority’s position that F must, upon commencing the placement at School C, become a looked after child...[because]… But for this placement the local authority would be providing high levels of social care support via other channels, so it cannot be said that the decision has been reached purely on educational grounds.”

54. Mrs M responded on the same day. She referred the Council to case law and SEND’s decision in order to argue against the Council’s claim. The Council replied on the Monday and said it would not pursue making F a looked after child.

55. Mrs M says this shows a misunderstanding of the law and caused unnecessary stress to Mr and Mrs D.

56. The case notes from the Council show that on 11 August 2016 a manager had reviewed the case and decided F should be made a looked after child. The manager recorded that “F is a child who clearly has social care needs....It is highly unlikely that parents would have ever been able to manage his care without ongoing support.” The Council received legal advice the following evening which said F should not be made a looked after child. This was because the tribunal’s decision for F to attend a residential school was based only on F’s education needs.

57. The role of the Ombudsman is to identify fault leading to significant personal injustice. There was fault by the Council in initially appearing to misunderstand the tribunal’s decision. I appreciate the Council’s email may have caused some distress to Mr and Mrs D, but the Council quickly amended its decision. I consider that to be an appropriate response and that no significant injustice was caused.

Agreed action

58. I have found fault causing injustice as set out in paragraphs 33-36 and 41.

59. The Council should apologise to Mr and Mrs D:

- for the delays in completing the functional OT assessment, which meant that F missed out on six months of OT provision during the 2014/15 academic year.

- for the failure to secure respite care from a befriender service from August 2015 to April 2016

60. Where fault has resulted in a loss of provision, the Ombudsman's guidance on remedies recommends a payment to acknowledge the impact of that loss.

61. The Council should therefore also pay £3,000 and the personal budget amount for the befriender service that was not provided from August 2015 to April 2016, to be used for F's educational benefit.

Final decision

62. The Council failed to ensure an OT assessment was carried out on time and that respite care was provided. This caused injustice to Mr and Mrs D and their son.

63. I have not found fault causing injustice in the rest of the complaint. Some parts of the complaint are out of the Ombudsman's jurisdiction.

64. The Council has agreed to my recommended actions and I have completed my investigation.

Parts of the complaint that I did not investigate

c) The Council failed to appropriately assess and acknowledge the extent of their son's special educational needs.

65. Mr and Mrs D complain the Council did not assess F's SEN needs properly. The issue of whether the Council had met F's sensory needs formed a key part of the appeal to SEND. This means the Ombudsman cannot consider this matter. Where a complainant has exercised their right of appeal in any court of law the Ombudsman has no discretion to investigate ***(Local Government Act 1974, section 26(6)(a)).*** This is the case even if the appeal may not provide or have provided a complete remedy for all the injustice claimed. ***(See R v The Commissioner for Local Administration ex parte PH (1999) EHCA Civ 916.)***

g) The Council failed to comply with a Subject Access Request within the prescribed time.

66. This is not a matter for the Ombudsman. It is instead a matter for the Information Commissioner's Office (ICO). The ICO deals with complaints from members of the public who believe that an authority has failed to respond correctly to a request for information. I can see no reason why Mr and Mrs D could not refer the matter to the ICO.

h) The Council failed to implement Occupational Therapy recommendations.

67. Mrs M complains the recommendations in the August 2015 OT report were not acted on. She says that the Council failed to confirm until the SEND hearing that it agreed with the recommendations or that it had found an OT to work with F during the school day. She also complains the Council refused to confirm whether the OT would attend the hearing.

68. These are not issues the Ombudsman can consider. If Mr and Mrs D felt the OT's report should be included in the statement, they had the right to appeal to SEND. They did this in November 2015. As I explain above this prevents me from considering this matter.

69. Mrs M has asked the Ombudsman to consider reimbursing costs incurred by Mr and Mrs D as a result of their appeal to SEND. But this is not a matter the

Ombudsman can consider. This is because the issue of costs has already been considered by SEND in July 2016.

i) There was an overall failure to meet their son's needs.

70. Mrs M says "There was overwhelming evidence available to the Local Authority as to the extent of F's needs and the provision / type of school placement that he required to meet these needs. However, the failure of the Local Authorty to acknowledge these and to name School C in Part 4 of F's Statement of SEN, meant they failed to meet his needs."

71. Mr and Mrs D appealed the school named in F's statement to SEND. So this is not a matter the Ombudsman can consider.

Investigator's decision on behalf of the Ombudsman

5 April 2018

Complaint reference:
17011637

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's draft decision

Summary: Ms X complains the Council failed to carry out a safeguarding investigation and wrongly told her to refer the matter to another local authority. Errors in how the Council allocated the referral caused delays and it was its responsibility to investigate the matters reported. The Council has already taken action to put right the faults including completing the safeguarding investigation and apologising to Ms X.

The complaint

1. Ms X complains the Council failed to carry out a safeguarding investigation and wrongly said she should refer the matter to another local authority.

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. As part of the investigation, I have:

- considered the complaint and the documents provided by the complainant;
- made enquiries of the Council and considered the comments and documents the Council provided;
- discussed the issues with the complainant;
- sent my draft decision to both the Council and the complainant and taken account of their comments before making my final decision.

What I found

5. Ms X made a safeguarding referral to the Council in June 2017. She had concerns about her mother, Mrs Y, saying she was subjected to controlling behaviour by her sister, Ms Z.

6. The Council accepted the referral and decided it met the criteria for a safeguarding investigation though it was not an urgent case. An officer phoned Ms X to discuss the issues in more detail. Ms X was particularly concerned about Ms Z's financial control and that she was preventing Mrs Y seeing a close friend she previously lived with.

7. The Council referred the matter to its older adults team. Due to staffing problems it did not immediately allocate the case to a social worker. A team manager decided to allocate the case to herself as a temporary measure. However, she did not have the required computer access so allocated it to the previous team manager, officer B.

8. When Ms X contacted the Council about the progress of her safeguarding referral, she was told it was being dealt with by officer B. This officer did not know that officer B no longer worked for the Council and so provided her email address and telephone number. Ms X sent emails and left voicemail messaged but got no response.

9. After making a complaint, the case was referred to a social worker. He contacted Ms X on 11 September and found out Mrs Y was now living in Wales with Ms Z. The social worker took the decision the safeguarding concerns would need to be investigated by the local authority in Wales. He also advised Ms X to contact the Office of the Public Guardian about concerns relating to the misuse of Mrs Y's finances.

10. A social worker from Wales advised Ms X and the Council that it could not investigate alleged abuse that happened in Nottinghamshire. The case was then referred to a team manager for consideration.

11. The Council wrote to Ms X on 6 October 2017 in response to her complaint about the delays and poor handling of her referral. As well as explaining the reasons for the delay and providing an apology, the Council also provided details of its safeguarding investigation and outcome.

12. In the letter, the Council explained it had reviewed Mrs Y's records. This included a mental capacity assessment from April 2017 carried out by an independent social worker. This found Mrs Y had capacity to make decisions about where she lived. It found she did not have capacity to make financial decisions.

13. As part of its investigation the Council also spoke to Mrs Y, Ms Z and Mrs Y's close friend. It also considered information provided about the process by which Mrs Y signed a Lasting Power of Attorney (LPOA). As part of this process Mrs Y met with a consultant from an estate planning company. Information was also provided from a solicitor involved in producing Mrs Y's will.

14. The Council concluded that while there was evidence of an ongoing family dispute (between Ms X and Ms Z) there was no evidence to show Mrs Y was being forced to make decisions against her will. The Council closed the safeguarding case as unsubstantiated and with no evidence of any ongoing risk to Mrs Y.

Analysis

15. There is fault in how the Council responded when Ms X made a safeguarding referral in June 2017. It delayed in allocating a social worker and then compounded this delay by allocating it to a former worker. This meant the Council did not realise its mistake until Ms X made a formal complaint.

16. I note the Council accepted its fault when responding to Ms X's complaint on 6 October 2017. It provided an apology for the delays and it has reviewed procedures to ensure a similar mistake does not happen again. The Council was wrong to say Ms X should refer the matter to Wales as the referral made in June met the safeguarding criteria. The Council has corrected this by conducting a safeguarding investigation.

17. Ms X is dissatisfied with the safeguarding investigation saying a more thorough investigation is required. I am satisfied the Council did carry out a proper investigation of Ms X's concerns. It spoke to Ms X more than once about her concerns. It reviewed Mrs Y's file. It spoke to Mrs Y, Ms Z and Mrs Y's close friend to get more information about the move to Wales, whether Mrs Y had the mental capacity to make such a decision and about whether she was forced into decisions. The Council then used its professional judgement to decide no abuse was taking place. I can see no basis to criticise this decision.

18. Regarding any financial abuse, Ms Z holds the LPOA for Mrs Y. The Council has quite correctly advised Ms X that she should contact the Office of the Public Guardian if she has concerns that Ms Z is misusing Mrs Y's finances.

Final decision

19. I will complete my investigation as the Council has already taken action to put right the fault that occurred in this case.

Investigator's decision on behalf of the Ombudsman

4 May 2018

Complaint reference:
16 013 060
C2029788

Complaint against:
Nottinghamshire County Council
Nottinghamshire Healthcare NHS Foundation Trust

Local Government & Social Care OMBUDSMAN

Parliamentary and Health Service Ombudsman

The Ombudsmen's final decision

Summary: The Council delayed completing capacity assessments for a vulnerable adult about their social care. The Council failed to keep the daughter informed at certain stages. The various bodies involved did not co-ordinate well in the best interests of the service user. This led to increased upset for the service user's daughter.

The complaint

1. The complainant, who we will call Ms B says:

a) The Council failed to act in the best interests of her mother (Mrs D).

b) The Council wrongly said Mrs D had capacity to decide not to have works to her bathroom. Ms B says because the works were not completed Mrs D could not shower and did not wash properly. Mrs D was sat covered in urine which soaked into her clothes and slippers and resulted in a hospital admission for sepsis.

c) The Council did not include Ms B in the decision not to do the works to the bathroom.

d) The Council delayed taking action to deal with mice and potentially other pests at Mrs D's property.

e) The Council failed to take action about Ms B's sister in law (Mrs F) removing items from Mrs D's house.

f) The Council failed to complete a carers assessment for Ms B.

g) The Council said it would respond to the complaint by 25 May 2017 and failed to do so.

h) District nurses failed to alert the GP that Mrs D's legs were getting worse, or arrange further treatment.

i) Mrs D contracted sepsis because of poor care.

The Ombudsmen's role and powers

2. The Local Government and Social Care Ombudsman investigates complaints about adult social care providers. We decide whether their actions have caused an injustice, or could have caused injustice, to the person making the complaint. Where something has gone wrong we refer to those actions as 'fault'. ***(Local Government Act 1974, sections 34B, and 34C, as amended)***

3. The Health Service Ombudsman investigates complaints about 'maladministration' and 'service failure' in the delivery of health services. We use the word 'fault' to refer to these. If there has been fault, the Health Service Ombudsman considers whether it has caused injustice or hardship. ***(Health Service Commissioners Act 1993, section 3(1))***

4. If the actions of a health and social care provider have caused injustice, the Ombudsmen may suggest a remedy. Our recommendations might include asking the organisation to apologise or to pay a financial remedy, for example, for inconvenience or worry caused. We might also recommend the organisation takes action to stop the same mistakes happening again.

How we considered this complaint

5. We considered:

- Information provided by Ms B, and discussed the complaint with her.
- Responses to our enquiries from the Council and NHS Trust.
- The Mental Capacity Act 2005, and the associated 'Code of Practice' produced by the Department for Constitutional Affairs.
- The Mental Health Act 1983.
- The Care Act 2014 and associated statutory guidance.

What we found

6. Mrs D lived alone at home. Mrs D had dementia, chronic leg ulcers, and deafness, among other conditions. Ms B was Mrs D's main carer, alongside care workers coming in a few times a day arranged by the Council.

7. Due to Mrs D's dementia, she could not manage her finances. The Court of Protection appointed the Council as her deputy for property and finances.

8. Mrs D had incontinence, which she failed to accept and would not wear continence products. Because of this she often had accidents, which meant she was sat in urine. This made her already sore legs worse. The District Nurses were involved at various stages to care for the sores on Mrs D's legs.

9. Mrs D also received support from the NHS Trust's mental health services.

10. Mrs D died in hospital on 25 November 2016.

Mental capacity

11. Mental capacity is the ability to make a decision. When we talk about 'a person who lacks capacity' it means a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken. People may lack capacity for some decisions but not for others. Some people may lack capacity to make a decision at a certain time, but may be able to make that decision at a later date.

12. The Mental Capacity Act 2005 (MCA) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.

13. The five statutory principles are:

- Every adult has the right to make their own decisions if they have the capacity to do so. Family carers and healthcare or social care staff must assume that a

person has the capacity to make decisions, unless it can be established that the person does not have capacity.

- People should receive support to help them make their own decisions. Before concluding that individuals lack capacity to make a particular decision, it is important to take all possible steps to try to help them reach a decision themselves.
- People have the right to make decisions that others might think are unwise. A person who makes a decision that others think is unwise should not automatically be labelled as lacking the capacity to make a decision.
- Any act done for, or any decision made on behalf of, someone who lacks capacity must be in their best interests.
- Any act done for, or any decision made on behalf of, someone who lacks capacity should be an option that is less restrictive of their basic rights and freedoms – as long as it is still in their best interests.

Capacity assessments regarding works to bathroom and continence

14. The NHS Trust's Intensive Recovery Intervention Service (IRIS), which is part of its mental health services for older people, recommended that Mrs D might benefit from a wet room. This was referred to the Council to consider doing the works under a disabled facilities grant; which the Council agreed in May 2016.

15. In June 2016, the Council's deputyship officer asked for a best interest decision regarding works to the bathroom and associated costs. As a deputy, you're responsible for helping someone make decisions or making decisions on their behalf. You must consider someone's level of mental capacity every time you make a decision for them, you can't assume it's the same at all times and for all kinds of things.

16. Two occupational therapists from the Council visited Mrs D to complete a test of capacity about installing a walk-in shower. They also discussed replacing a chair and carpet in the living room. They record the deputy had received reports the items were a risk due to their declining state. However, it is clear from correspondence on file the concerns were around incontinence and resultant staining of the chair and carpet. The Council also had information that Mrs D's feet would get covered in faeces and her legs were ulcerated and being treated by the District Nurses.

17. When assessing ability to make a decision the MCA guidance says you should consider:

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to this decision?
- Can the person communicate their decision?

18. The Council assessed Mrs D using the above criteria and decided she had capacity to decide about installing the walk-in shower and replacing a chair and carpet. Mrs D decided she did not want these items.

19. Ms B is aggrieved that she was not involved in the decision making. It was appropriate for the Council to assess Mrs D's capacity free of any other influence. As the Council decided Mrs D had capacity to make the decision there was no need for it to include any other party. Mrs D could make decisions that Ms B, and involved professionals, may consider unwise.

20. The Council would only be required to involve Ms B in the decision making if Mrs D did not have capacity and it needed to make a decision in Mrs D's best interests. In those circumstances MCA guidance recommends involving relevant family and professionals.

21. However, the focus about the chair and carpet at this assessment was on them being a hazard because of their declining state. Three months later the Council assessed Mrs D's capacity about managing continence. The Council assessed Mrs D did not have capacity to decide about her continence management. The Council completed a best interests decision, including Ms B and relevant professionals. The Council decided the chair and carpet should be replaced in Mrs D's best interests.

22. The Council had the information about continence concerns when it made the earlier capacity decision. In our view, the capacity assessment for continence should have been carried out sooner. Especially given concerns from healthcare professionals and Ms B.

23. Because capacity is time and decision specific we cannot know what the result might have been three months earlier. Mrs D may have had capacity at that time to decide about her continence; even if her decisions were considered unwise by others. But, it leaves uncertainty about whether the Council and NHS Trust could have improved Mrs D's circumstances. Had they changed the chair and carpet it could have alleviated some of the concerns about Mrs D's living conditions and impact on her health and wellbeing. Ms B understandably felt the Council and NHS Trust were ignoring her concerns as nothing was happening to improve her mother's situation.

24. Changing the chair and carpet was not completed after the Council assessed Mrs D did not have capacity, as she died while arrangements were advancing.

25. In addition to the Council completing capacity assessments, the NHS Trust was concerned about Mrs D's living situation so carried out mental capacity assessments with a view to detaining her under the Mental Health Act. The NHS Trust decided Mrs D had significant impairment that was impacting on her life, but did not consider her to be at a stage that required detention. In the NHS Trust notes it is evident they felt Mrs D did not have capacity about her problems and the associated risks. Ms B says a Doctor told her that Mrs D did not have capacity. However, there is no evidence that NHS staff completed a capacity assessment about any individual specific decisions at a specific time to enable it to say Mrs D did not have capacity about that issue. The conflicting information given to Ms B caused real distress, and an unfair view that the Council was wrong in its actions.

Safety of property

26. Following a call to Mrs D's property the ambulance service referred to a local fire station for a fire safety assessment of Mrs D's home. The ambulance service did not advise any other body. The fire service contacted the Council for Ms B's contact details to arrange the inspection.

27. The fire service completed the inspection and had concerns about the safety of the electrics. It graded the property as high risk until the electrical system could be upgraded.

28. A planned multi agency meeting did not go ahead due to staff sickness. Despite all the concerns about Mrs D's welfare, the Council did not rearrange the meeting.

29. Mrs D did not accept any works were needed to her property and did not wish to leave. The Council sought legal advice. The legal advice said if incapacity is established then the Council must do a best interests decision to establish whether it would be the least restrictive for the person to be supported in their own home or that they need residential/nursing care. If a person is to be removed against their wishes then the Council must seek authority from the court of protection. If the removal needs to take place urgently then an urgent application can be made to the court of protection. The Council would have to evidence why it was urgent and why the person could not be supported by other means until the application could be considered by the usual route. Only if there was a significant risk of imminent harm or death could the Council remove the person without the protection of the court or the Mental Health Act.

30. Ms B sought electrician quotes. The first quote advised the electrics in the utility were not safe to be used; the care workers could no longer complete laundry. Ms B said she would take the risk and do it in the meantime.

31. The Council assessed Mrs D's capacity about having electrical works done, and decided she did not have capacity on this issue. However, this was six weeks after the fire officer said the property was high risk. And a month after the legal advice which said the first step was to find out capacity on the issue. Given the safety concerns we would have expected the Council to progress matters quicker than it did.

32. The next day Mrs D was admitted to hospital. The Council took this opportunity to try and arrange the electrical works, and works to chair and carpet, while Mrs D was out of the house. Unfortunately, Mrs D died in hospital within that week.

District Nurses

33. A district nurse will visit and treat patients in their own home. The district nurses were involved with Mrs D to care for wounds on her legs. In February 2016, a care worker reported a wound to Mrs D's leg that needed dressing. The NHS says the district nurses visited daily, and on occasions every four days, depending on clinical need. However, the records show on several occasions when it is noted to visit the next day there is no record that it happened. This leaves doubt over whether Mrs D was getting the visits she needed.

34. The wounds to Mrs D's legs were made worse by her refusal to accept she was incontinent and to wear incontinence products. Mrs D would urinate where she was sitting, and the urine would soak down her legs and feet. The district nurses were essentially managing a continuing problem that was unlikely to improve unless there was a change in the continence issue.

35. The records show on 19 November 2016 the district nurses visited to change dressings, which were wet through with exudate fluid (which may come from areas of infection or inflammation). The district nurse cleaned the wound and redressed it. On 21 November 2016, the district nurses visited and noted the wounds on the back of both legs looked sloughy (skin was coming off), but it was difficult to see as Mrs D could not lift her legs up properly while in the chair. The district nurse records she did not ask Mrs D to stand up. It would have been

prudent to ask Mrs D to stand to try and assess her legs fully, of course Mrs D may not have been agreeable to comply. The district nurse cleaned the wound and redressed it.

36. On 22 November 2016 Ms B called the district nurses to say her mother had gone to hospital following a fall, so did not need the visits at present. The hospital diagnosed an infection. Mrs D died three days later due to sepsis, which is a rare but serious complication of an infection.

37. The district nurse records were available for Mrs D's GP to review electronically. The NHS says there was no indication that the patient had sepsis or any underlying infection that could have developed into sepsis.

38. Ms B says she and the carer's noted the day before that Mrs D was sleepy and not her normal self. However, the NHS website does not list tiredness as a sign of sepsis. Being tired would not be something in itself which would require care workers or NHS staff to seek medical attention.

39. The ambulance crew recorded that Mrs D was very hot, this is not listed as a sign of sepsis. The tiredness and temperature could have been a sign of the infection which caused the sepsis, but there is no evidence that care workers or NHS staff should have taken any action sooner than they did. The ambulance was called following Mrs D falling, which was appropriate and which identified an underlying issue which was not obvious prior to the fall.

Pest control

40. Mrs D saw her GP about possible bites, the GP noted spots which may have started as insect bites. The care agency workers and the health care workers failed to tell the Council about this issue; the Council found out by a report from Ms B. The Council says it referred the matter to the district council's Environmental Health team though I have seen no evidence of that.

41. The Council asked Ms B to catch one of the bugs and bring it to its office to examine. Ms B tried but could not even see the bugs to be able to catch one. Ms B also raised a concern about mice.

42. Six weeks later an Environmental Health officer (EH officer) visited the property. The EH officer found no evidence of a mite, flea or insect infestation, but did find evidence of mice. The EH officer advised Ms B to block up the hole where mice were getting in. The district council's website says once you lodge a request for pest control it aims to carry out any treatment within two working days. The delay of six weeks is fault; it is unclear when the county council made the referral to EH, and whether it chased the matter.

Safeguarding

43. Ms B and her sister in law raised various concerns with the Council about the other. This meant the Council had a duty to consider those concerns under its safeguarding policy.

44. 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. ***(section 42, Care Act 2014)***

45. Ms B raised concerns about her sister in law removing a letter from Mrs D's property, and does not feel the Council took appropriate action in response.

46. The Council's procedure says that feedback should be given to the referrer and other relevant individuals.

47. The Council wrote to Ms B and said the threshold for social care involvement was not met. The letter said further investigation was needed to establish any evidence to support the allegation. The Council would investigate it as part of an ongoing investigation.

48. The Police were involved and interviewed Mrs F who denied the allegation. The Police identified there was no eye witness, and there were also two care workers and Mrs D's grandson at the property that day.

49. The Council interviewed Mrs F about the allegations made by Ms B, both about the missing letter and various other issues. The Council decided there was not enough evidence to substantiate a safeguarding investigation. It was one person's word against another.

50. Although the Council closed Ms B's enquiry, it should have updated her of the overall result as a relevant individual. Its failure to do so left Ms B feeling that no action was taken. However, I consider Ms B's injustice is limited, the Council's letter said to contact it for any further advice on the matter; I have seen no evidence Ms B did this.

Carers assessment

51. Where an individual provides or intends to provide care for another adult and it appears the carer may have any needs for support, local authorities must carry out a carer's assessment. Carers' assessments must seek to find out not only the carer's needs for support, but also the sustainability of the caring role itself. This includes the practical and emotional support the carer provides to the adult. ***(Care and Support Statutory Guidance 2014)***

52. When Ms B found out she may be entitled to support as a carer for her mother she asked the Council for an assessment.

53. The Council failed to complete a carers assessment for Ms B because of a current safeguarding investigation in which she was the alleged perpetrator. If the Council had upheld the safeguarding then it may have decided Ms B was not a suitable person to provide care for her mother, and the carers assessment would become irrelevant.

54. While we accept this reasoning, the Council knew for many years that Ms B was providing informal support to her mother. The Council should have recognised Ms B as a carer and offered her a carers assessment much earlier, and without her needing to ask for it. This means Ms B may have missed support she was eligible for.

Complaint handling

55. Councils should have clear procedures for dealing with social care complaints. Regulations and guidance say they should investigate a complaint in a way which will resolve it speedily and efficiently. A single stage procedure should be enough. The Council should say in its response to the complaint:

- how it has considered the complaint; and
- what conclusions it has reached about the complaint, including any matters which may need remedial action; and
- whether the responsible body is satisfied it has taken or will take necessary action; and

- details of the complainant's right to complain to the Local Government and Social Care Ombudsman.

(Local Authority Social Services and National Health Service Complaints (England) Regulations 2009)

56. The Council's website says social care complaints will follow the complaints process, which says in most cases it will deal with the complaint and respond within 20 working days. In adult social care cases like this one, the Council says it aims to reach a resolution within six months. Individual correspondence with complainants gives details about response times.

57. We recognise that Ms B made complaints in a piecemeal way, which made it slightly harder for the Council to deal with. But, the Council often missed deadlines which it gave, this exacerbated Ms B's upset and frustration with the Council's service. However, we also recognise the Council did keep Ms B updated of changes to timescales.

58. It took the Council seven months to provide a final response which directed Ms B to the Ombudsman, this is outside of its aim of six months to resolve adult social care complaints. We find its published information is not clear on the procedure it will follow, and gives insufficient information on what to expect.

59. Ms B says she did not receive the Councils final response. I note the Council says it sent it by letter on 25 May 2017; all previous correspondence was sent by e-mail and letter. Ms B had previously asked for correspondence by e-mail so that she could keep it all in one place. The Council failed to comply with Ms B's preferred communication method, which resulted in her not receiving its final response. Ms B says she did not chase it as she had given up by that stage, and came to the Ombudsmen.

Conclusions

60. Many different bodies were involved in Mrs D's care. They did not co-ordinate well together to act in Mrs D's best interests. Ms B received conflicting information regarding her mother's capacity, which led her to believe the Council was not acting correctly.

61. We fully understand Ms B's concerns for her mother's welfare and how distressing it must have been seeing her mother living in those conditions. Ms B would know, as did the professionals involved, that Mrs D's refusal to manage her incontinence was not in Mrs D's best interests. The professionals involved could have taken action about this sooner than they did, as the concerns were known several months before the Council completed its mental capacity assessment and best interests decision about continence.

62. Although Ms B wanted immediate change, as she was concerned for her mother, the professionals involved had to follow due process. They could not force something upon Mrs D that she did not want if she had the capacity to choose. The professionals also had to weigh up the impacts on Mrs D of making major changes to her home environment, and of any move from her property. So, even if the capacity assessment about continence was completed sooner, it still would have taken some time to make appropriate arrangements.

63. We must say that this would be a distressing situation even if there was no fault involved, but we recognise the actions in this case exacerbated Ms B's upset.

64. The Ombudsmen cannot say Mrs D contracted sepsis solely because of the actions of the Council and NHS Trust.

Agreed actions

65. To acknowledge the impact of the identified failings the involved bodies have agreed to the following actions:

a) The Council apologises for its delays, failures to keep Ms B informed, and failures to co-ordinate fully with the various bodies involved. The Council should pay £400 to recognise the impact of its failings on Ms B. It should complete this within one month of the Ombudsmen's final decision.

b) The NHS Trust apologises for its failure to co-ordinate fully with the various bodies involved. This should be completed within one month of the Ombudsmen's final decision.

c) The Council should look at the reasons for its delays in this case, consider what improvements could be made, and advise the Ombudsmen accordingly within three months of the final decision.

d) The Council look at the reason it failed to send the complaint response of 25 May 2016 by e-mail in line with Ms B's preference. If it does not have a system in place, it should consider how it can accurately record someone's communication preferences and ensure they are met. The Council should complete this within three months of the Ombudsmen's final decision, and report back to the Ombudsmen on the action taken.

e) The NHS Trust considers why all district nurse visits are not recorded. It should remind staff of the importance of maintaining accurate and contemporaneous records. It should complete this within three months of the Ombudsmen's final decision, and report back on the actions taken.

f) Both bodies consider ways of better collaborative working. The Council and NHS Trust could agree a lead officer in cases such as this. The lead officer would take responsibility for providing information to relatives and professionals to ensure a consistent approach. The Council and NHS Trust should complete this within six months of the Ombudsmen's final decision, and report back on actions taken.

Final decision

66. I have completed my investigation on the basis the agreed actions are sufficient to acknowledge Ms B's injustice and prevent future problems.

Investigator's decision on behalf of the Ombudsmen

19 April 2018

Complaint reference:
17019041

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman cannot investigate this complaint about a Penalty Charge Notice because the complainant appealed to the tribunal.

The complaint

1. Mr B disagrees with the fine the Council issued when he parked in an area where there was a loading restriction. Mr B wants the Council to answer his questions and to waive the fine.

The Ombudsman's role and powers

2. The Local Government Act 1974 sets out our powers but also imposes restrictions on what we can investigate.
3. We cannot investigate a complaint if someone has appealed to a tribunal or a government minister or started court action about the matter. ***(Local Government Act 1974, section 26(6), as amended)***

How I considered this complaint

4. I considered the information provided by Mr B and the Council. This included copies of all documentation relating to Mr B's penalty charge notice.
5. Mr B had the opportunity to comment on a draft of this decision.

What I found

What happened

6. The Council issued Mr B, who has a blue badge, with a penalty charge notice because he was parked in a street when loading/unloading restrictions were in force.
7. Mr B challenged the penalty charge notice but the Council refused this challenge.
8. Mr B appealed to the Traffic Penalty Tribunal. It said that whilst blue badge holders may park on single or double yellow lines, they may not park where there is a loading restriction. The Tribunal took into account the civil enforcement officer's photographs which showed there was a clearly marked parking restriction.
9. The tribunal adjudicator dismissed the appeal and said the contravention occurred.

Analysis

10. I cannot start an investigation because Mr B appealed to the Tribunal. The law says the Ombudsman cannot investigate any matter that has been considered by a Tribunal. This restriction applies even if Mr B disagrees with the outcome of the appeal and with the Penalty Charge Notice.

Final decision

11. The Ombudsman cannot investigate this complaint. This is because Mr B has appealed to the Tribunal.

Investigator's decision on behalf of the Ombudsman