

Complaint reference:
16 011 497

Complaint against:
Nottinghamshire County Council

The Ombudsman's final decision

Summary: The Council acted in line with safeguarding procedures when responding to allegations made by Ms B and against her. A senior officer also acted in line with a standard authorisation when advising Ms B not to take her father Mr C out of his care home. There was a deprivation of Mr C's liberty for two weeks in July 2015 which was not covered by an authorisation. This is fault. The Council has agreed to apologise to Ms B and Mr C for the avoidable distress.

The complaint

1. Ms B complains about Nottinghamshire County Council (the Council). She complains about the way the Council responded to allegations about her late father, Mr C. Ms B says:
 - a) The Council did not check the accuracy of information it received from other parties
 - b) Despite the allegations being unfounded, the records state she is an alleged perpetrator. She has not received an apology
 - c) She was not interviewed as part of the safeguarding investigation
 - d) A standard authorization was backdated
 - e) She was prevented from visiting her father at the care home
 - f) She was only permitted to contact one officer in the Council
 - g) There was a failure to address her concerns about the care regime at the care home

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. If there has been fault, we consider whether it has caused an injustice and if it has, we may suggest a remedy. (*Local Government Act 1974, sections 26(1) and 26A(1)*)
3. If we are satisfied with a council's actions or proposed actions, we can complete an investigation and issue a decision statement. (*Local Government Act 1974, section 30(1B) and 34H(i)*)

How I considered this complaint

4. I considered Ms B's complaint to the Ombudsman and supporting documents. I also considered the Council's responses to her complaints and some of the

Council's records on Mr C. I have taken into account comments from the parties on a draft of this statement.

What I found

Relevant law and guidance

5. The Mental Capacity Act 2005 is the legal framework for acting and making decisions for people who lack the mental capacity to do so themselves. The Act and the Code of Practice 2007 describe the steps a person should take when dealing with someone who may lack capacity. It describes when a person's capacity to make a decision should be assessed, how to do this, and how to make a decision on behalf of somebody who is unable to make a decision themselves.
6. A council must assess someone's ability to make a decision, when a person's capacity is in doubt. The action needed to assess capacity may vary depending on the complexity of the decision.
7. 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 done, or made, 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 also has to consider if there is a less restrictive option available that can achieve the same outcome. If there is a conflict about what is in a person's best interests, and all attempts to resolve the dispute have failed, the court of protection might need to decide what is in the person's best interests.
8. A Lasting Power of Attorney (LPA) is a legal document, which allows people to choose one person (or several) to make decisions about their health and welfare and/or their finances and property, for when they become unable to do so for themselves. The 'attorney' is the person chosen to make a decision, which has to be in the person's best interests. There are two types of LPA:
 - Property and Finance LPA – this gives the attorney(s) the power to make decisions about the person's financial and property matters, such as selling a house or managing a bank account.
 - Health and Welfare LPA – this gives the attorney(s) the power to make decisions about the person's health and personal welfare, such as day-to-day care, medical treatment, or where they should live.
9. An Independent Mental Capacity Advocate (IMCA) is a legal safeguard for people who lack capacity to make decisions about where they live and serious medical treatment options. An IMCA supports the person and represents them in discussions, provides information to help work out what is in their best interests and presents the person's views to the decision maker.
10. The Deprivation of Liberty Safeguards (DOLS) framework protects people who lack capacity to consent to being deprived of their liberty in a care home or hospital and who are not detained under the Mental Health Act 1983. People are instead detained by a standard or urgent authorisation. The care home or hospital applies to the supervisory body (a team in the local authority) which carries out six assessments including an assessment of best interests to decide whether to approve a standard authorisation. An urgent authorisation can be put in place by the care home or hospital itself until the local authority has carried out the relevant assessments for a standard authorisation.

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11. A relevant person's representative (RPR) can be a paid professional or a lay person who knows the person subject to a standard authorisation. Their role is to:
 - Keep in contact with the person being deprived of their liberty;
 - Represent and support the person, including by using complaints' procedures or applying to the Court of Protection.
 12. If a council has reasonable cause to suspect abuse of an adult who needs care and support, it must make whatever enquiries it thinks is necessary to decide whether any action should be taken to protect the adult. (*Care Act 2014, section 42*)
 13. I have summarised relevant parts of the Council's safeguarding policy below:
 - Section 42 enquiries (see paragraph 12) have stages including: initial discussions, assessing risks agreeing actions for agencies to take, protection plan, review, closure. Not every case goes through every stage.
 - Attendance at meetings limited to those who need to know and who can contribute to the decision-making process.
 - The Council may signpost to other processes and organisations where this would be a more proportionate and appropriate response
 - The safeguarding manager gives feedback to the referrer.

Key facts

Background

14. Mr C had Parkinson's disease and dementia. Ms B's complaint covers 2014 and 2015 when Mr C was mainly in hospital. Mr C had mobility problems after surgery which Ms B claims was negligent. Mr C's care was arranged and funded by the NHS and not by the Council. Ms B registered powers of attorney for health and welfare and finances for Mr C in January 2015.
15. Before hospitalisation in 2014, Mr C lived at home with his wife Mrs C who has mental health problems. They had a joint package of home care.
16. Mr C remained in hospital for many months after surgery and had rehabilitation. Nursing staff monitored him closely as he had poor awareness of the risks of walking without assistance and many falls were documented in the records.
17. In October 2014, there was a safeguarding referral to the Council by an occupational therapist (OT). The OT said he observed Ms B slapping her mother in June 2014. The Council wrote to the OT to say there would be a strategy meeting under its safeguarding procedures. I have no documentation to suggest a meeting or discussion took place when the safeguarding referral was made. It appears that no action took place under safeguarding procedures at the time.
18. Mr C went home with a care package in October 2014. He had a fall in January 2015 and was readmitted to hospital. The ambulance crew made a safeguarding referral because they found the house was cold and thought Mrs C was 'delusional'. The Council considered this information and decided there should be a further social care assessment when Mr C was ready to be discharged.
19. In March 2015, ward staff made a safeguarding referral saying Ms B not acting in her father's best interests. Ms B was alleged to have been abusive to hospital staff. She was alleged to have taken Mr C off the ward in a wheelchair against

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- staff advice. The Council's safeguarding team decided to take no further action as the referral did not meet the threshold for a safeguarding investigation.
20. On 16 June 2015, the ward submitted an application for a standard authorisation to deprive Mr C of his liberty. Mr C was receiving close observation and supervision by nursing staff at all times. Meantime, the hospital granted itself an urgent authorisation to 22 June which was extended to 29 June.
 21. There was no authorisation to deprive Mr C of his liberty from 29 June as the assessments for a standard authorisation had not been completed.
 22. A best interests' assessor (BIA) assessed Mr C as lacking capacity to consent to care and treatment. The BIA spoke to Ms B on 29 June. The BIA noted Ms B was broadly in agreement with Mr C remaining in hospital, but had concerns:
 - about the deprivation of liberty, saying this was not necessary;
 - about the length of time he had been in hospital and wanted her father to be discharged home. Ms B felt he did not need a standard authorisation; his care had not changed so it was unclear why the hospital was seeking an authorisation;
 - that her father's mental health had deteriorated in hospital;
 - that the orthotic department and physiotherapists gave her conflicting information about whether Mr C should walk or not. She felt staff were stopping him from walking.
 23. The Council sought legal advice given Ms B's concerns and objections. The advice was if the relevant criteria were met, then the authorisation should be granted.
 24. The BIA noted Ms B told her not to continue with the process of applying for a standard authorisation. I have seen the email and consider it contained an indirect threat against the BIA. The BIA noted Ms B told her not to ring, but to email or write.
 25. A best interests' assessment dated 28 June recommended a standard authorisation to come into force as soon as possible. The BIA concluded close observation of Mr C was a proportionate response to the likelihood of harm and was the least restrictive option. The other assessments needed for a standard authorisation took place at the beginning of July. The standard authorisation document was dated 16 July and was to last until 2 November.
 26. On 10 July, the BIA emailed Ms B with information about the role of the RPR (see paragraph 11). She also updated Ms B about the assessments she had been doing (see previous paragraph). The BIA asked Ms B if she wanted to be Mr C's RPR. She explained Ms B could have an advocate to support her.
 27. Ms B responded to the BIA's email. I have seen a copy of the email and its content may have caused the recipient BIA distress. Ms B did not directly reply to the BIA's question about whether or not she was willing to be Mr C's RPR.
 28. It appears from the records the BIA planned to recommend Ms B as Mr C's RPR (there is a form naming Ms B as the RPR) but then on 16 July, the ward manager told her Ms B could not visit the ward.
 29. The BIA emailed Ms B on 16 July to say she had completed her assessment and would send Ms B a copy of the standard authorisation. The BIA said she had requested a paid RPR because of restrictions on Ms B visiting her father on the ward.

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30. The following day, Ms B emailed a manager to complain about not being appointed RPR. She said there were no problems with her contact arrangements with the ward. She said she felt bullied and not consulted.
31. On 21 July, the hospital made a safeguarding referral. It said:
- Ms B was unrealistic about her father's care needs and her access to the ward had been limited;
 - Ms B felt her father could mobilise and had capacity to refuse support;
 - The discharge team said Mr C needed 24-hour support but Ms B felt this was not necessary.
32. The Council decided further safeguarding enquiries were required as Ms B had been abusive to ward staff and there was a risk she may be abusive to carers visiting the home. And a further risk Mr C's wife may not allow carers into the property. There was a concern Ms B may not be acting in her father's best interests.
33. A service director responded to Ms B's complaint (see paragraph 30) saying the records showed the BIA had spoken with Ms B several times and Ms B had not replied to the BIA's question about her being RPR. The service director said if Ms B wanted to take on the role, she should contact the team manager.
34. The Council wrote to Ms B at the end of July saying she was now Mr C's RPR.
35. On 14 August, there was a further safeguarding referral from hospital staff. A member of the public reported seeing a woman hit a man in a wheelchair in the face and kick the wheelchair. Officers from the Council's safeguarding team discussed the referral and decided to review the CCTV and liaise with the police. The outcome was no investigation was required as the informant told the police she had not actually witnessed an assault.
36. Ms B wrote to a service manager saying there was an unauthorised deprivation of her father's liberty in June and at the beginning of July. She said she had questioned ward staff and they were not aware that authorisation was required.
37. On 14 September, Mr C moved to a care home. This was funded by the NHS. There is no evidence the Council funded the placement, although the DOLS team was aware of it as the hospital sent them a form saying the standard authorisation expired when Mr C left hospital.
38. The care home granted itself an urgent authorisation on 15 September. This was to last a week and was then extended for a further week.
39. On 16 September, the care home made a safeguarding referral saying Ms B wanted to transfer Mr C to a different care home and the manager had received an email intended for the other care home. A social worker spoke to staff at the care home. Staff from the NHS organisation funding Mr C's placement had spoken to Ms B and she had agreed he would stay at the care home for 4 weeks. The Council took no action under safeguarding procedures.
40. On 29 September, the care home made another safeguarding referral saying a member of the public had called the care home to say they had seen Ms B shout at Mr C and hit him.
41. A standard authorisation was signed on 5 October, and dated to come into force on 2 October. It authorised a deprivation of Mr C's liberty for 6 weeks. The best interests assessment documents Ms B's views in detail: she felt the authorities

were overriding her, she pointed out her father owned the house, felt her mother would tolerate carers and believed her father would get better care on a one to one basis. The BIA decided it was in Mr C's best interests to remain in the care home (which was a locked unit where he was under close supervision) until care at home could be arranged. The authorisation was for 6 weeks and the BIA recommended the Council and NHS applied to the Court of Protection if a home care package could not be organised within 6 weeks – unless Ms B was happy for Mr C to continue to remain at the care home.

42. Ms B made a safeguarding referral on 6 October saying during one of her visits, her father did not open his eyes for half an hour while awake and that the Trust had illegally overridden her as the power of attorney by placing Mr C in the care home. A safeguarding officer discussed this with Mr C's social worker who said the issues were not safeguarding concerns and that Ms B could visit Mr C, just not take him out of the care home. The decision was there were no safeguarding issues. The Council wrote to Ms C confirming there would be no further action under safeguarding procedures as her concerns did not amount to neglect.
43. On 7 October, a group manager wrote to Ms B to tell her the police had received an allegation that she had assaulted Mr C. The letter advised Ms B that a standard authorisation was in place and at present she should not take Mr C out. She could visit and phone him. The letter said the Council and NHS would apply to the court of protection for guidance on Mr C's future care because she had asked for her father to be moved and professionals did not consider this was in his best interests at the moment. The group manager asked Ms B to communicate with the complaints team.
44. Ms B replied to the group manager's letter saying she had not been able to see her father for a week. She raised concerns about the standard authorisation being backdated. She asked if she could take her father out if another person was present. She said she agreed to the placement at the care home continuing as a temporary option until Mr C could be discharged home.
45. The Council appointed Ms B as Mr C's RPR and wrote to her to inform her of this on 20 October. Ms B wrote back asking the DOLS team to send copies of the urgent and standard authorisations. She pointed out errors in the paperwork including factual errors like Mr C's date of birth. She queried backdating of the authorisation.
46. On 28 October, Ms B made another safeguarding referral. She alleged her father was over sedated. A social worker made enquiries of the care home and found out Mr C was prescribed a sedative. She asked staff to get the GP to review his medication. Staff said they had served notice. The social worker spoke to Ms B who told her the heating was too high, residents were not fed nutritional diets and staff were not interested in residents. The Council later wrote to Ms B saying it was not progressing with a safeguarding investigation as there was no evidence to suggest lasting harm or distress and Ms B should discuss any further concerns with Mr C's social worker.
47. Mr C went home on 9 November. The standard authorisation expired.
48. On 24 November, there was meeting of professionals including safeguarding social work staff, the NHS organisation funding Mr C's care package and an officer from the Public Guardian (the public guardian oversees attorneys). The purpose of the meeting was to discuss all the previous allegations about Ms B. The minutes noted:

- There had been five safeguarding referrals involving Ms B;
- Ms B had spoken to a team manager the week before the meeting. She denied hitting her father. She agreed a discussion became heated when the OT was present but denied hitting her mother. She said she had slapped Mr C's hand to make him let go of a handrail and kicked the wheelchair brake to get him back inside. Before the incident outside the care home, Ms B said her father had bashed her over the head with drink so she threw the bottle down in front of him. Ms B said she had complained to the Trust about a surgical error and felt hospital staff were making malicious allegations;
- The Public Guardian's Office was looking into Mr C's finances and had asked Ms B for documents;
- The outcome of the safeguarding investigation was inconclusive: there had been a number of allegations made but there was no evidence to substantiate any of them;
- Mr C was now at home with one to one care so there was no future risk.

49. The Council's investigation of Ms B's complaints found:

- There was no fault in the way the safeguarding investigation was conducted;
- Temporary restrictions on her visits to Mr C were reasonable;
- It was not appropriate to appoint her as RPR while safeguarding investigations were ongoing;
- Allocating a single point of contact was appropriate because Ms B had contacted several council officers.

Was there fault?

Complaint: The Council did not check the accuracy of information it received from other parties

50. I am satisfied the Council made appropriate checks with the police about the alleged assaults and other incidents involving Ms B. A senior officer also spoke to Ms B before the professionals' meeting in November 2016 and this gave her the chance to put her side of the story. This information was taken into account by professionals at the meeting who decided not to substantiate the allegations.
51. There was no witness evidence to corroborate assaults (either the witnesses were not willing to give statements or they confirmed that they had not actually witnessed an assault) and so no further action was taken. This is in line with the Council's safeguarding procedures which make it clear that not all cases go through every stage. There is no fault.
52. The hospital OT was a member of NHS staff. There appears to have been a delay in the OT reporting an alleged assault (whether the report was in October 2015 as suggested in the case conference minutes, or October 2014, as correspondence suggests). The OT was not acting for the Council and so I have no power to criticise the delay.
53. I do not uphold the complaint because I consider the Council took steps to check the information, including checking with Ms B to get her side of the story. Having done appropriate checks, the Council decided there was insufficient evidence to take any further action. The Council acted without fault.

Complaint: Despite the allegations being unfounded, the records state she is an alleged perpetrator. She has not received an apology

54. It is correct to say the records refer to Ms B as an alleged perpetrator as this is what she is – someone who has had allegations made against her. However, the records make it clear that abuse was not substantiated. There is no fault.

Complaint: She was not interviewed as part of the safeguarding investigation

55. The minutes of the case conference noted a manager spoke to Ms B on 17 November about the allegations, before the professionals met to discuss the allegations. There is no fault.

Complaint: A standard authorization was backdated

56. The Council accepted in the complaint response that it should not have backdated the second standard authorisation (at the care home). It has apologised.
57. There was also a two week period from 29 June 2015 when an urgent authorisation expired and 16 July when a standard authorisation came into force. This means Mr C was deprived of his liberty without the protection of a standard authorisation. This is not in line with the Deprivation of Liberty Safeguards and is fault.

Complaint: Ms B was prevented from visiting her father at the care home

58. According to Ms B, she was prevented from visiting her father at the beginning of October. I see no evidence that the Council had any involvement in preventing a visit and so I do not uphold this complaint against the Council. I cannot comment on the care home's actions as Mr C's care was arranged and funded by the NHS. Ms B has complained to the Parliamentary and Health Service Ombudsman which has power to investigate complaints about NHS funded healthcare.
59. The Council had written to Ms B saying she could not take him out of the care home. This was in line with the standard authorisation which deprived Mr C of his liberty and so there is no fault.

Complaint: Ms B was only permitted to contact one officer in the Council

60. There are two direct records of inappropriate comments from Ms B to council staff. There is no fault in the Council deciding she should only contact one officer. I consider this was an appropriate means of managing her contact.

Complaint: There was a failure to address Ms B's concerns about the care regime at the care home

61. Officers in the safeguarding team considered Ms B's concerns about the care home and decided they did not meet the appropriate threshold to be dealt with as safeguarding issues. This is in line with council safeguarding policy which makes it clear that not all concerns raised are appropriate to deal with through safeguarding. The Council acted in line with section 42 of the Care Act 2014 and there is no fault.

Did the fault cause injustice requiring a remedy?

62. The Council recognised it should not have backdated the second standard authorisation and has apologised to Ms B for the distress to her. That is an appropriate remedy.
63. There was also a two week period before the first standard authorisation came into force. This may have caused Mr C distress. Ms B was certainly caused

avoidable distress because there is evidence she raised concerns in writing about the lack of a standard authorisation with the Council (see paragraph 36).

Recommended action

64. To remedy the avoidable distress to Mr C and Ms B described in the previous paragraph, the Council will apologise to them within one month of my final decision.

Final decision

65. The Council acted in line with safeguarding procedures when responding to allegations made by Ms B and against her. A senior officer also acted in line with a standard authorisation when advising Ms B not to take her father out of the care home.
66. There was a deprivation of Mr C's liberty for two weeks in July 2015 which was not covered by a standard authorisation. This is fault. The Council has agreed to apologise to Mr C and Ms B for the distress caused.

Parts of the complaint I did not investigate

67. Mr C's care was arranged and funded by the NHS so complaints about the standard of care in hospital or in the care home are for the Parliamentary and Health Service Ombudsman to consider.

Investigator's decision on behalf of the Ombudsman

Complaint reference:
17 011 847

Complaint against:
Nottinghamshire County Council

The Ombudsman's final decision

Summary: We will not investigate this complaint as it is unlikely we can add to the Council's own investigation or achieve the outcome Mr Y seeks.

The complaint

1. The complainant, whom I shall call Mr Y, complains he was harassed at a Council waste depot when he visited it to deposit garden waste.

The Ombudsman's role and powers

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

How I considered this complaint

3. I have considered what Mr Y said in his complaint.

What I found

4. Mr Y complains he was shouted at by a Council employee in front of other members of the public when he attended a waste depot to deposit garden waste. Mr Y says the employee told him he could not unload his garden waste as he had tools in his van implying that Mr Y was trying to deposit trade waste.
5. Mr Y says the same employee approached him last year in a similar way. Mr Y feels this is harassment. Mr Y is also unhappy that the Council in its early complaint responses said that he had refused to fill in a disclaimer form.
6. The Council says that any CCTV footage at the site is unlikely to provide evidence to support Mr Y's complaint as it does not record sound. The Council says that as Mr Y's account and staff accounts are conflicting, it cannot make a determination of what happened. The Council now acknowledges that Mr Y did not refuse to fill in a trade waste disclaimer form as its staff did not ask him to do so on this occasion.

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7. The Council explains that residents must sign a trade waste disclaimer form if asked to do so and that such requests might be made when a resident takes large loads to the depot or makes frequent visits or when there are tools in a vehicle. The Council explains it is not wrong for its staff to enforce this policy and does not accept that Mr Y has been singled out. The Council says it accepts Mr Y has a large garden and that there is no need to make a visit or that a visit would change how it applied its rules.
 8. Mr Y remains of the view that he has been badly treated. He wants the Council to apologise and to visit his home to see that his large garden does generate the large volume of garden waste that he takes to the depot.

Analysis

9. It is unlikely we can add to the Council's own investigation or determine what happened during the incident that Mr Y complains about without any independent, corroborating evidence. Even if we could, while we appreciate Mr Y remains unhappy, any outstanding injustice caused to him is not at a level that would warrant our involvement. We would not generally investigate a complaint just to secure an apology.
10. The Council is entitled to refuse to visit Mr Y's property and we cannot make it do so.

Final decision

11. We will not investigate this complaint as it is unlikely we can change the outcome of the complaint or achieve the outcome that Mr Y seeks.

Investigator's decision on behalf of the Ombudsman

Complaint reference:

LGO reference: 16 017 845

PHSO reference: 2014194

Complaint against:

Nottinghamshire County Council (the Council)

Nottingham North and East Clinical Commissioning Group (the CCG)

The Ombudsmen's final decision

Summary: Mr X complains about the Council and CCG's decision to refuse funding for a care package at home. The Ombudsmen do not find fault with this decision as it took the decision based on the risks to Mr X if he returned home. The Council and CCG are considering alternative options in discussion with Mr X.

The complaint

1. Mr X complains about the care services the CCG and Council have provided for him. In summary:
 - Mr X disagrees with the Council and CCG's decision in October 2016 to refuse funding for a home care package.
 - Mr X considers the Council and CCG have failed to explore residential placement alternatives if a return home is not possible.

The Ombudsmen's role and powers

2. The Ombudsmen have the power to jointly consider complaints about health and social care. Since April 2015, these complaints have been considered by a single team acting on behalf of both Ombudsmen. (*Local Government Act 1974, section 33ZA, as amended, and Health Service Commissioners Act 1993, section 18ZA*).
3. The Ombudsmen investigate complaints about 'maladministration' and 'service failure'. We use the word 'fault' to refer to these. If there has been fault, the Ombudsmen consider whether it has caused injustice or hardship (*Health Service Commissioners Act 1993, section 3(1) and Local Government Act 1974, sections 26(1) and 26A(1), as amended*).
4. If it has, they 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.
5. If the Ombudsmen are satisfied with the actions or proposed actions of the bodies that are the subject of the complaint, they can complete their investigation and issue a decision statement. (*Health Service Commissioners Act 1993, section 18ZA and Local Government Act 1974, section 30(1B) and 34H(i), as amended*)

How I considered this complaint

6. I have discussed the complaint with Mr X. I have also made enquiries of the Council and CCG. I have considered the responses and supporting case notes, correspondence and assessments.
7. I have taken into account relevant law and guidance before coming to a view. I have also issued a draft decision on the complaint and invited comments from the parties.

What I found

Key facts

8. Mr X has multiple sclerosis with associated long-term conditions. He is not mobile and requires assistance with most activities of daily living. He has lived in a Neurodisability unit (the Unit) since 25 July 2016.
9. The Council completed a review for Mr X on 26 July 2016. It completed the review by telephone as Mr X had been hospitalised for pneumonia and had moved to the Unit the previous day on a trial basis.
10. The Council wrote to Mr X on 25 October 2016. The letter explained that the Council had decided a return home was not appropriate. This was based on the fact Mr X's previous care packages at home had repeatedly broken down. The Council considered it would be putting Mr X at risk if it supported him to move home. As it was likely any further care packages at home would break down, leaving Mr X without support.
11. Mr X's advocate complained on his behalf. The Council replied in December 2016. It reiterated that it considered Mr X would be at risk if he returned home.

Relevant law and guidance

12. Sections 9 and 10 of the Care Act 2014 require councils to carry out an assessment of any adult who appears to need care and support. They must assess anyone, regardless of their finances or whether the council thinks they have eligible needs. The assessment must be of the adult's needs and how they impact on their wellbeing and the outcomes they want to achieve. It must involve the individual and where appropriate their carer or any other person they might want to be involved.

Analysis

13. The 2016 assessment confirmed Mr X needs assistance in most areas and this could have a significant impact on his wellbeing. The assessment concluded he required 11.5 to 12 hours support during the day and support from a second carer for six to six-and-a-half hours a day. The assessment noted a multi-disciplinary team would review his placement at the Unit in 10 weeks. It recorded Mr X's needs had increased.
14. The assessment records Mr X's care package is funded jointly by the Council and the CCG. I have therefore treated the Council's actions being partly on behalf of the CCG.
15. Mr X clearly has very complex needs. The Council and CCG have a duty to meet those needs in a way that is appropriate. While I appreciate Mr X wishes to return home, I cannot conclude the Council is at fault in taking the decision Mr X's needs should be met in the Unit. The Council made its decision based on evidence

available to it relating to the likelihood of a care package at home breaking down. It has explained its decision to Mr X. I therefore do not consider there is evidence of fault.

16. Since making the complaint, the Council and CCG have entered into further discussions with Mr X about his care needs. The following events have occurred in the intervening period that are relevant to this complaint:
 - On 16 June 2017 a social worker and occupational therapist met with Mr X to discuss his care needs. They determined he required a live-in carer in order to meet his complex needs.
 - Mr X previously lived in a one-bedroom property. On 20 June 2017 Mr X's housing provider advised there was no accommodation for carers on the property.
 - On 14 July 2017 Mr X's social worker decided to speak with Mr X to determine whether he would consider a move to an alternative property in the community that would accommodate a live-in carer. However, she also considered that Mr X may wish to arrange his own care in his current property. The note explains there would be a joint discussion with the CCG to consider a care package for Mr X at home. However, given previous arrangements had broken down due to Mr X's behaviour, a care package at home would leave him at risk.
17. Mr X wishes to return home. I am satisfied that the Council and CCG are in ongoing discussions with Mr X to determine whether this is appropriate. Based on the events since this complaint, I am satisfied the Council and CCG are reconsidering this possibility – including this risks to Mr X. I am therefore satisfied with the actions the CCG and Council are taking to resolve the matter. I am also satisfied there are ongoing discussions about an alternative if Mr X is unable to return home. I therefore do not consider there is evidence of fault as there is evidence alternative options are in discussion should Mr X be unable to return home.

Final decision

18. I do not consider there is evidence of fault in the Council's initial decision to refuse to support Mr X to return home. It made its decision based on the high level of risk this would pose to Mr X. It explained this to Mr X.
19. The Council and CCG are in ongoing discussions with Mr X about the most appropriate way to provide for his needs. I am therefore satisfied with these actions and have completed my investigation on this basis.

Investigator's final decision on behalf of the Ombudsmen

Complaint reference:
16 017 763

Complaint against:
Nottinghamshire County Council

The Ombudsman's final decision

Summary: Mr B complains that the Council has unreasonably delayed in dealing with a Definitive Map Modification Order for a Right of Way over a nearby Green Lane. The Ombudsman has closed his investigation into the complaint because he considers that the Council has dealt with the application in accordance with its procedures.

The complaint

1. Mr B complains that there has been unreasonable delay by the Council in processing a Right of Way application for a nearby "*Green Lane*". He says the path has been blocked since 2013 and feels that the Council has failed in its duty to keep open a Right of Way which has been used for over 100 years.
2. Mr B has not used the path often so the personal injustice to him is limited. But he considers that its closure has caused an injustice to many people living close to the path who used it and signed a petition. He also considers it in the public interest that the Council deal with Right of Way applications promptly.

What I have investigated

3. I have exercised discretion to investigate Mr B's complaint about delay from the time of the making of the Order in April 2015.

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 investigate late complaints unless we decide there are good reasons. Late complaints are when someone takes more than 12 months to complain to us about something a council has done. (*Local Government Act 1974, sections 26B and 34D, as amended*)

How I considered this complaint

6. I have considered Mr B's written complaint and spoken with him. I have made enquiries of the council and considered its response. I have also sent Mr B and the Council a draft decision and invited their comments.

What I found

Recording Rights of Way

7. Every County Council or Unitary Authority in England (except the inner London boroughs) must prepare and keep up-to-date a “*Definitive Map*”. This shows every Right of Way (RoW) in an authority's area and the nature of the rights over the paths shown.
8. To record a RoW on a Definitive Map, it is necessary to apply for a Definitive Map Modification Order (DMMO). If an authority decides that a “*reasonable allegation*” can be made, it must make an Order to record the RoW. If no objections are received, it will then confirm the Order and record the RoW on the Definitive Map.
9. However, if it receives objections, it must send the Order to the Secretary of State (in practice the Planning Inspector) for a decision. An Inspector will then either consider written evidence or hold a Planning Inquiry. The Inspector may either confirm or not confirm the Order, or support the Order in a modified form, in which case there would be further consultation and consideration of the evidence.
10. There is no statutory timetable to submit an Order or refer an Order to the Secretary of State. However, six weeks must be allowed for each statutory public consultation.

What happened

11. Mr B lives close to a short Green Lane that runs between two roads, Road 1 and Road 2. The upper part of the Green Lane runs alongside a corner plot on Road 1, which a developer has bought and has been seeking to develop.
12. Mr B has explained that, in 2013, the developer put a fence across the top of the Green Lane, blocking access. He understands that the property deeds say that the developer owns land up to the centre of the Green Lane. But he says the deeds also say the landowner must keep the Green Lane open and not hinder passage. However, the Green Lane has been closed for four years.
13. In November 2013, an interest group filed a DMMO application to register the Green Lane as a RoW. The Council carried out pre-consultation in February 2014. After further research and internal approvals, it made a DMMO in April 2015. It then undertook the statutory consultation during which it received representations both in favour and against the making of the DMMO.
14. Mr B had previously contacted the Council about the DMMO but had not heard anything further since an update letter from the Council in December 2014. In March 2017, he complained to the Council about delay in dealing with the DMMO.
15. The Council explained that it had made the Order in April 2015 and received objections but, due to several internal issues, matters had not progressed significantly since then. Recently, however, officers had contacted objectors to confirm if their objections remained. If so, the Council would proceed with preparing a submission to the Secretary of State.
16. Mr B complained again to the Council about excessive delay in dealing with the DMMO. The Council reiterated the reasons for the time taken to deal with the application, which included staff shortages, increased workload and giving priority to other casework with set timescales. It explained that it had kept the applicant informed of developments.
17. The Council apologised for the time taken, and recognised that this was an unreasonably long process for Mr B, but considered that it had followed its

procedures correctly. It explained that it now had a fully staffed Team, it was preparing the report for the Secretary of State and it should now be able to reduce the backlog of cases.

My assessment

Delay in dealing with the DMMO

18. Mr B has complained of unreasonable delay in dealing with the DMMO which he considers to be clear evidence of fault by the Council.
19. There are no statutory timescales for the Council to follow in processing a DMMO apart from the six-week statutory consultation period. However, councils have a duty to prepare and keep up-to-date the Definitive Map.
20. The Council has explained that from 2015 onwards, its RoW Team experienced severe staffing pressures:
 - the Senior Definitive Map Officer left the Council and was not immediately replaced due to budget uncertainties;
 - there was a lengthy period of staff sickness;
 - in July 2016, the Government brought in compulsory searches from District and Borough Councils – this increased searches from around 1,400 to over 9,000 a year, and took staff away from other roles;
 - also in 2016, many Council Highways functions, and relevant staff, were transferred to a new company, so the remaining Team had to re-organise and recruit suitably qualified and experienced staff;
 - uncertainty over how the transfer to the new company would affect workload, and changes to budget allocations, meant that it was not possible to recruit staff earlier - the Team has only recently reached full capacity.
21. The Council says that, during this period of change, the Team had to prioritise work with statutory timescales for completion, such as legal orders from Highways England, Planning Authorities, compulsory searches from District Councils, and issues affecting residents' safety.
22. However, there were no periods where work on DMMOs stopped. Instead, in accordance with its procedures the Council processed applications in order of receipt with some exceptions. It followed the same procedure where it received objections.
23. One exception is where a regularly used path is fenced off, as in this case. However, the Council would also normally prioritise routes such as rural paths where there is no suitable alternative route. In this case, although the Council accepts that the closure of the Green Lane causes inconvenience to residents, there is a suitable alternative along publicly adopted highways.
24. That said, the Council has increased this case's priority and employed a consultant to prepare a detailed Statement of Case to send to the Planning Inspectorate. This will require further research, interviewing witnesses and preparation of proofs of evidence. When the Council has completed this process and referred the case, the Planning Inspectorate will provide a date for an inquiry to be held locally. There will be a strict timetable for all parties to submit evidence.
25. I have considered whether the way the Council has dealt with matters would constitute fault. This process has taken a long time to reach this point, and I appreciate that this has caused Mr B some frustration.

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26. It seems to me, however, that the Council has faced significant resourcing issues and changes to both its staffing and workload over this period. Although it has had to deal with these factors, it has prioritised its work according to its procedures. It has also continued to prepare DMMOs to update the Definitive Map. On balance therefore, despite the time taken to deal with the DMMO, I am not persuaded that the way the Council has acted constitutes fault.

Action to unblock the path

27. Mr B has also complained that the Council has allowed the path to remain blocked and has not acted to reopen it.
28. The Council has explained that under section 130(1) of the Highways Act 1980 *“it is the duty of the Highway Authority to assert and protect the rights of the public to the use and enjoyment of any highway”*. Section 130(7) of the same Act states that *“proceedings or steps taken by a council in relation to an alleged right of way are not to be treated as unauthorised by reason only that the alleged right is not found to exist”*.
29. So, a Highway Authority can take action on an unrecorded path if it has reasonable and proper belief that it is a highway. But in the Team Manager’s experience, this would be a unusual and only with very strong evidence.
30. In this case, the Council has reasonably alleged that a public highway exists, hence its making a DMMO. But it has also received objections and the consultant is undertaking research and interviews before sending the Council’s case to the Planning Inspectorate. The Council needs to act proportionally when considering enforcement action and be confident of the strength of its evidence. Besides in this case there is an alternative route for members of the public on foot. Therefore, the Council has no current plans to take enforcement action.
31. I see no fault in the way the Council has considered this, so it is not for me to question the Council’s decision not to take action.

Final decision

32. I have closed the complaint because I consider that the Council has dealt with the DMMO in accordance with its procedures.

Parts of the complaint that I did not investigate

33. Mr B considers that I should investigate the way the Council has dealt with these matters since early 2014. He says he did not complain to the Ombudsman earlier because he understood the matter was progressing.
34. Mr B was aware that the path had been blocked since 2013 but had heard nothing from the Council since December 2014. I appreciate that he may not have known that limited progress was being made on the DMMO, but had he contacted the Council or the Ombudsman earlier, he could have found out where matters stood. Although I have exercised discretion to consider events since the Order was made in April 2015, I see no good reason why Mr B could not have complained earlier. So I have not investigated matters prior to April 2015.

Investigator’s decision on behalf of the Ombudsman

Complaint reference:
17 006 110

Complaint against:
Nottinghamshire County Council

The Ombudsman's final decision

Summary: There was fault by the Council and its contractors in not adequately anticipating the needs of the people who would be likely to apply for the course. This meant the complainant had to wait longer to receive the training than he could reasonably have expected. The Council will, within one month of the date of this decision, pay Mr B £880.

The complaint

1. Mr B complains the Council did not meet its duties under the Equality Act 2010 to meet his needs as a disabled person. He applied for a home computer tuition course for disabled people. The Council and the agents it employed were not able to meet his needs and deliver the course.

The Ombudsman's role and powers

2. 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*)
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*)

How I considered this complaint

5. I considered the complaint and spoke to Mr B. I asked the Council for its comments on the complaint and additional information. I sent a copy of a draft of this statement to Mr B and the Council and invited their comments.

What I found

Background

6. In the summer of 2015 the Council's then contractor, provider X, advertised a home-based training scheme to provide up to 24 training hours in computer skills and the use of the internet. The course was for people who because of their disability were either unable to attend a course outside their home or found it very difficult to do so. Two of the conditions were that the person had a disability and be in genuine need of ICT training in their home. The course was to provide a 12 hour introduction to ICT. It was to focus on basic ICT skills (if needed) including the use of the internet and email. It could be followed by a further 12 hours if the learner wanted.
7. Mr B is registered blind. He applied for the course and was accepted. Mr B has some very limited sight and wanted tuition to assist him in using adaptive technology.
8. The Council no longer uses provider X so it has been unable to provide any information about any discussion that was had with Mr B about the suitability of the course to meet his desired outcomes. Nor has it been able to provide any information about the steps taken by provider X to find a suitable tutor for Mr B. But by June 2016 a suitable tutor had not been found.
9. In August 2016 the Council appointed a new provider, provider Y. In summary a tutor was found who started work with Mr B in late October. By Christmas it was clear the tutor did not have the necessary knowledge of the particular software and technology that Mr B needed. By February the Council had identified a charity that worked with blind and visually impaired people to provide the training. Mr B did not want to proceed on this basis because the times offered were not convenient because of his business commitments.
10. Mr B complained to the Council. The Council's first response offered 10 hours tuition by the charity. The second response upheld parts of Mr B's complaint and offered 16 hours tuition provided by the charity.

Assessment

11. The providers who offered the course were acting on behalf of the Council. Under the Equality Act the Council should anticipate the needs of any disabled person who might use the services it provides.
12. The Council has said that it and its subcontractor "had anticipated meeting the needs of a visually impaired person, by commissioning and developing a model of training delivery that did not require the learner to access a venue outside of their home." I do not consider this went far enough. It would be reasonable to think that a visually impaired person would apply for the training offered. That person may well need special equipment or training. The fact that no trainer could be found for a year and when one was identified they did not have the degree of knowledge required shows the Council and its contractors had not adequately anticipated the needs of a visually impaired person. This is fault.
13. This failure meant Mr B did not get the training the Council's agents had agreed to provide for 18 months. He bought a computer with the adaptive technology which he has not been able to use.
14. The Council now identified a trainer it considers can meet the training needs of Mr B. I have seen nothing that suggests that this provider could not meet Mr B's needs. I understand that this is not now Mr B's preferred option. The Council has

agreed to pay Mr B £880 being the cost of the training so he can arrange his own training. I consider this is a satisfactory resolution of the complaint.

Agreed action

15. Within one month of the date of this decision the Council will pay Mr B £880.

Final decision

16. There was fault by the Council and its contractors in not adequately anticipating the needs of the people who would be likely to apply for the course. This meant the complainant had to wait longer to receive the training than he could reasonably have expected. The Council will, within one month of the date of this decision, pay Mr B £880.

Investigator's decision on behalf of the Ombudsman

Complaint reference:
17 011 659

Complaint against:
Nottinghamshire County Council

The Ombudsman's final decision

Summary: The Ombudsman will not investigate this complaint that the Council's cleaners removed and damaged items belonging to the complainant. This is because he cannot add to the Council's response and there is no meaningful outcome he could achieve.

The complaint

1. The complainant, whom I refer to as Mrs X, says the Council's cleaning team removed and damaged items during a deep clean. Mrs X wants the Council to reimburse her for the lost items.

The Ombudsman's role and powers

2. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word 'fault' to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. We provide a free service, but must use public money carefully. We may decide not to start an investigation if we believe:
 - it is unlikely we could add to any previous investigation by the Council, or
 - it is unlikely further investigation will lead to a different 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), as amended)

How I considered this complaint

3. I read the complaint and the Council's response. I invited Mrs X to comment on a draft of this decision.

What I found

What happened

4. The Council arranged for its cleaning team to clean Mrs X's house. The Council says it told her, in advance, that the cleaners would remove any item that was detrimental to health.
5. Mrs X subsequently contacted the Council to say that many items were either missing or damaged. For example, she reported that a lot of alcohol and clothes were missing.

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6. In response, the Council interviewed the cleaners who said they only removed items which were detrimental to health. This included items which had perished or were heavily soiled. The Council inspected the bags of rubbish and did not find any of the reported missing items. The Council said it could not consider the complaint further but it passed the case to its insurers.

Assessment

7. I will not start an investigation because it is unlikely I could add to the Council's response. The Council has spoken to the cleaners and searched the rubbish. But, it has been unable to find evidence to support Mrs X's complaint. Given that I did not witness the events, and could not do any more than what that the Council has done, then it is unlikely an investigation would lead to a different outcome.
8. In addition, the Council has acted appropriately by passing the case to its insurers. The insurers, not the Ombudsman, will assess if the Council is liable for any losses.

Final decision

9. I will not start an investigation because it is unlikely it would lead to a different outcome and because it is appropriate for the insurers to assess the claim.

Investigator's decision on behalf of the Ombudsman

Complaint reference:
17 012 319

Complaint against:
Nottinghamshire County Council

The Ombudsman's final decision

Summary: The Ombudsman will not investigate Mrs A's complaint about the Council's decision to treat her mother in law, Mrs B, as depriving herself of assets. This is because there is not enough evidence of fault with the actions taken by the Council to warrant an investigation by the Ombudsman.

The complaint

1. The complainant who I shall call Mrs A says the Council should not treat her mother in law, Mrs B, as depriving herself of assets for the purpose of avoiding care costs, because when Mrs B gifted her house to her sons in 2010 she could not have known she would need residential care in 2017.

The Ombudsman's role and powers

2. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word 'fault' to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. We provide a free service, but must use public money carefully. We may decide not to start or continue with an investigation if we believe:
 - it is unlikely we would find fault, or
 - it is unlikely we could add to any previous investigation by the Council, or
 - it is unlikely further investigation will lead to a different outcome, or
 - we cannot achieve the outcome someone wants.

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

How I considered this complaint

3. I considered the information provided by Mrs A and the Council. I sent Mrs A a copy of my draft decision and considered her comments on it.

What I found

4. Mrs A is unhappy with the Council's decision to treat the house Mrs B owned but gifted to her three sons in 2010 as capital. Mrs A says Mrs B has not deprived herself of assets so she doesn't have to pay for her care. Mrs A says Mrs B did not know she would have needed residential care seven years after gifting her house.

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 6. The Council says when it interviewed Mrs B's son and Power of Attorney, he signed a financial assessment to say the house was transferred 'to protect it from being used to fund care fees'. The Council says the house was transferred to Mrs B's sons in April 2011.
 7. The Council says its records from 2011 show Mrs B fell twice and requested hand rails and equipment to help her get in and out of the bath. It also says Mrs B had, had several health problems and was unable to maintain her personal hygiene.
 8. The Care Act 2014 says a Council should consider:
 - 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?
 - did the person have a reasonable expectation of needing to contribute to the cost of their eligible care needs?
 9. The Council decided Mrs B should have known she may need care in the future and should not have gifted her house.
 10. Mrs A has not provided the Council with an alternative reason why Mrs B decided to gift her house to her sons in 2010. The Council has explained solicitors or financial advisors arranging a deed of gift or transfer of property have an obligation to advise their clients of the possibility that a Council may consider a person has deprived themselves of assets for the purpose of avoiding care costs. The Council says Mrs B could have left her property to her son's in her will to ensure they received any inheritance she wanted them to receive.
 11. If Mrs A has additional information about the reason why Mrs B transferred her house to sons in 2010 the Council has not seen she should ensure she provides it with this information so it can consider it further. The Ombudsman could not say the Council's actions have been taken with fault.

Final decision

12. The Ombudsman will not investigate Mrs A's complaint. This is because there is not enough evidence of fault with the actions taken by the Council.

Investigator's decision on behalf of the Ombudsman

Complaint reference:
17 010 801

Complaint against:
Nottinghamshire County Council

The Ombudsman's final decision

Summary: There was no fault in the Council's decision to refuse home to school transport for the complainant's daughter. There are no grounds to ask the Council to consider a further appeal.

The complaint

1. The complainant, whom I have called 'Mr B', is unhappy the Council has refused successive requests to provide his daughter (Child X) with free home to school transport.

The Ombudsman's role and powers

2. 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*)
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. Before issuing draft decision statement I considered:
 - Mr B's written complaint to the Ombudsman and further information provided in telephone conversations with this office and further email submissions.
 - Information provided by the Council including Mr B's application for Child X to receive free home to school transport and later appeals. I also considered correspondence sent to Mr B by the Council where it refused his request and gave its reasons for that decision.
 - The Councils free home to school transport policy for all children and its transport policy for children with special educational needs and disabilities; both of which are on its website.
 - The law as referred to in the text below.
 - Comments made by Mr B in response to a draft decision statement setting out my thinking about the complaint.

What I found

The law and Council policy

5. Section 444 of the Education Act 1996 says parents have a duty to make sure their children attend school.
6. To support parents in this duty, section 508B(1) and schedule 35B of the Education Act 1996 require councils to make home to school travel arrangements as they consider necessary for eligible children to attend their 'qualifying school'. The relevant qualifying school is the nearest school with places available that provides education suitable to the age, ability and aptitude of the child, and any special educational needs the child may have. The law defines 'eligible children' as those who:
 - cannot walk to school because of their special educational needs, disability or mobility problem;
 - cannot walk to school safely because of the route;
 - live outside the 'statutory walking distance' from the school (three miles for children over eight); or
 - can receive help on low income grounds.
7. Councils also have discretion under the 1996 Act to offer transport *"where they consider it necessary to facilitate the child's attendance at the school"*.
8. The Council's policy for home to school transport considers that usually the 'qualifying school' will be the child's 'catchment school'. So, it generally restricts help for secondary school children to those who attend their catchment school and only then in cases where the catchment school is more than three miles from the home address. The Council will make an exception for children who have a different preferred school closer than the catchment school but still more than three miles away. Also, to comply with the legal duty to support defined low income families the Council will sometimes fund other cases.
9. The policy also allows for some further limited 'exceptions to the rule'. It says that *"decisions to award free transport as an exception to policy are unusual but they do occasionally happen"*. It gives as examples cases such as children impacted by homelessness or those that must change schools following the Council's involvement.
10. Separately the Council publishes another policy on school transport for children with special educational needs and disabilities. It sets out the Council's legal duties and applies the same approach in expecting most children to attend their nearest catchment school. But it again explains that sometimes it will make an exception to its rules. It says there may be *"exceptional circumstances in which travel assistance may be offered"* where there are *"exceptional circumstances in individual cases"*.

The key facts in this case

11. Child X began secondary school in September 2016, meaning she is now in Year 8 of her education.
12. Child X attends a secondary school over five miles from her home address. Her nearest secondary school, which the Council defines as her catchment school, is around half a mile from her address.

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13. When Child X began secondary school, she attended with her sister, who was then in her final year of her secondary education (Year 11). Child X's sister received free home to school transport. This was under a discretionary scheme which began in 2011 but ended in August 2014 (i.e. pupils beginning secondary school after September 2014 could no longer benefit from this scheme).
 14. Mr B wanted Child X to attend the same school as her sister because she suffers from severe anxiety. Child X's sister would help her settle in at secondary school. Mr B describes Child X struggling to manage tasks independently. He says she cannot cross roads unaided. She needs constant reassurance and talks to her mother by phone several times during the school day. Mr B describes Child X receiving support from local CAMHS (Child and Adolescent Mental Health Services).
 15. Mr B first applied for school transport in August 2016. The Council turned down his request and then, in September 2016, turned down an appeal. Its decision letter said Child X did not qualify for free home to school transport because she did not attend her catchment school.
 16. In his letters of appeal Mr B has stressed the additional needs Child X has resulting from her anxiety as well as noting she suffers with epilepsy. In his view, the family had "*no choice*" but to send Child X to the preferred school so she could receive support from her sister. He has also explained that he cannot afford school transport for Child X and she has travelled on the school bus without paying since she began secondary school. Mr B is in employment but due to ill health works reduced hours. His wife is not in employment. Mr B says this is because of the time she spends talking and reassuring Child X and helping to meet her needs.
 17. Mr B pursued a second appeal, heard by a three-member panel of Council officers (including two service managers) in April 2017. They noted all Mr B described about Child X's health including that she was awaiting a possible diagnosis of autism. The Council also made enquiries of the School before deciding the appeal. It told them Child X was "*heavily reliant*" on her sister and they had concerns for how she would cope in Year 8. They explained Child X also experienced anxiety with the journey to school. It arranged support with this; for example, arranging for her to use the same seat on the school bus each day.
 18. The Panel said it was "*understandable*" Mr B chose to send Child X to the preferred school. But they decided she was not eligible for free home to school transport. This was after the Panel considered that Child X's catchment school also catered for children with additional or special educational needs. They also noted the journey to the school contributed to some of Child X's anxiety.
 19. In September 2017 Mr B again asked the Council to re-consider its decision. This followed Child X receiving a diagnosis of autism. The Council declined to consider the case again but it has given Mr B advice on Child X receiving an Education, Health and Care Plan (EHCP) because of her special educational needs. Currently Child X does not have an EHCP but is going through the procedure to get one.

My findings

20. I do not find fault in the Council's policy on home to school transport. I consider both its general policy and that specific to children with special educational needs or disabilities comply with the law. The Council has drawn those policies tightly, usually only restricting successful applications to those pupils legally entitled to

transport. But I find the Council entitled to do this. So long as it does not fetter its discretion it can choose to exercise any discretion it has sparingly.

21. When I refer to 'fettering discretion' I am referring to cases where councils refuse to make an 'exception to the rule'. The Council's policies allow it to make exceptions where it thinks there are special circumstances to do so.
22. The issue at the crux of this case is whether the Council has decided properly not to treat Child X's case as an exceptional case. To decide this the Council must take account of her individual circumstances. I found the Council's first appeal decision in September 2016 flawed because it made no reference to Child X's individual circumstances. It overlooked Mr B's stated reasons for sending Child X to the chosen secondary school given her anxiety and the impact this had on her.
23. But I cannot say the same about the second appeal heard in April 2016. The Panel minutes show that it carefully noted all the points Mr B made in his appeal. The Council also gathered information from the School which supported Mr B's statements about the extent of Child X's anxiety and the impact this had on her. The School's comments also showed Child X benefitted from the support of her sister as stated by Mr B.
24. Yet the Panel decided despite this evidence it could not treat Child X's case as a special case. In doing so, it introduced two further factors. First, that while the preferred school clearly made efforts to meet Child X's additional needs there was nothing to suggest the catchment school could not have done also. Second, that Child X also experienced anxiety with travel to school. Something that I consider confirmed by Mr B's statements also. The inference here was that attending the catchment school, with a shorter journey, might lessen some of Child X's anxiety.
25. I consider the Council entitled to introduce these factors. They were not irrelevant to its decision on whether Child X's case was a special case. I considered the Council entitled to decide these factors tipped the balance towards deciding Child X's case was not 'an exception to the rule'. They implied Mr B did have choice about where he sent Child X to school, despite his statements to the contrary. Mr B can disagree with its judgment but I consider it reasonable and soundly based on fact. As I explained above a disagreement is not a basis for me to find fault with the decision. The Council went through a proper and thorough process taking account of arguments for and against making an exception. So, I find no fault in how the Council decided the appeal.
26. I have gone on to consider whether the Council has subsequently been right to refuse Mr B a further appeal. I consider there is a gap in its policies in not explaining if there are circumstances where parents can ask the Council to consider a further application or appeal for home to school transport. I consider this would be appropriate if there are changes in circumstance relevant to a decision.
27. In this case Mr B has introduced Child X's diagnosis of autism. While this will clearly be relevant to her future education I do not consider on its own it provides grounds to ask the Council to look again at its decision on transport. At the April 2017 appeal, the Council knew Child X potentially had autism as she waited for a diagnosis. I presume the condition helps explain the difficulties she experiences with anxiety and carrying out tasks independently. But the diagnosis does not change the facts around her anxiety or independence, which Mr B used as the basis for his appeal. The Council knew and accepted in April 2017 that Child X was highly anxious and needed support to travel to school. So, while it is new

evidence I understand why the Council takes the view it will make no difference to its decision and I think that reasonable.

28. It could be that in time new facts emerge. And, as part of the EHCP procedure the Council will have to consider if Child X needs support to attend any school named on the plan. So, the Council will have to keep an open mind and might need to re-consider the position in the future. But I see no reason to fault its consideration of Child X's case up to now.

Final decision

29. For the reasons explained above I have not upheld this complaint finding the Council has not acted with fault. I have therefore completed my investigation satisfied with its actions.

Investigator's decision on behalf of the Ombudsman

Complaint reference:
17 012 461

Complaint against:
Nottinghamshire County Council

The Ombudsman's final decision

Summary: The Ombudsman cannot investigate Mr J's complaint about the content of a report for court.

The complaint

1. Mr J complains that the Council has prepared a report for court which misrepresents him, and this may affect his case for having contact with his child.

The Ombudsman's role and powers

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

How I considered this complaint

3. I have considered the information Mr J provided with his complaint.

What I found

4. Mr J has applied to court to arrange contact with his child. The court asked the Council to provide a report about Mr J. Mr J is unhappy about the content of the report and has complained to us about it.
5. But this is a complaint about what is happening in court. So it is not a matter we can investigate.

Final decision

6. We cannot investigate this complaint.

Investigator's decision on behalf of the Ombudsman