14 October 2021

Complaint reference:
20 008 978

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Mrs X complained about the residential care provided to her late father, Mr Y by M & M Care Limited. He received significant injuries and the family was given conflicting information. This caused them significant upset and distress and they would like to understand how this happened and ensure it does not happen to others. We find the Care Provider failed to follow Mr Y's care plan and this led to the significant injuries. We are satisfied sufficient action has been taken to prevent, as far as possible, this happening to others. Mrs Y and Mrs X do not want any financial remedy, so the Council has agreed to apologise and follow up when a safeguarding enquiry involves someone it placed.

The complaint

1. The complainant, whom I shall refer to as Mrs X, complained about the residential care provided at The Old Rectory, to her father, the late Mr Y who received significant injuries. These injuries triggered an alert to the Police and a safeguarding investigation. The care was provided by M & M Care Limited and commissioned by the Council.
2. Mrs X says this caused the family much upset and distress, especially to Mrs Y who had struggled with Mr Y moving to a care home. They would like a full explanation of what happened and how Mr Y received the injuries. They would also like to make sure similar problems do not happen to others.

The Ombudsman's role and powers

3. 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)***
4. If we are satisfied with a council's actions or proposed actions, we can complete our investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i), as amended)***
5. We may investigate a complaint on behalf of someone who has died or who cannot authorise someone to act for them. The complaint may be made by:
    - their personal representative (if they have one), or
    - someone we consider to be suitable.

(Local Government Act 1974, section 26A(2), as amended). In this case, we consider Mrs X a suitable person to complain on Mr Y's behalf.

How I considered this complaint

6. I considered information from the Complainant and from the Council.

7. I sent both parties a copy of my draft decision for comment and took account of the comments I received in response.

What I found

Background

The Care Quality Commission

8. The Care Quality Commission (CQC) is the statutory regulator of care services. It keeps a register of care providers who show they meet the fundamental standards of care, inspects care services and issues reports on its findings. It also has power to enforce against breaches of fundamental care standards and prosecute offences.

9. Regulation 9 is about personalised care. The CQC's guidance on the regulations says:

   - "Providers must do everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be".

10. Regulation 12 is about safe care and treatment. The guidance says:

    - "Providers must do all that is reasonably practicable to mitigate risks".
    - "Staff must follow plans and pathways".
    - "Incidents that affect the health, safety and welfare of people using services must be reported internally and to relevant external authorities/bodies. They must be reviewed and thoroughly investigated by competent staff, and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result. Staff who were involved in incidents should receive information about them and this should be shared with others to promote learning. Incidents include those that have potential for harm".
    - "Outcomes of investigations into incidents must be shared with the person concerned and, where relevant, their families, carers and advocates. This is in keeping with Regulation 20, Duty of candour".

11. Regulation 17 is about good governance. 17(2)(c) says care providers should "maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided".

What happened

12. Mr Y lived in The Old Rectory care home (the Old Rectory) run by M & M Care Limited (the Care Provider). He had various health conditions including dementia and had significant difficulties with mobility and understanding his needs. He

could be forgetful, confused, and found it difficult to find the right words. He occasionally became frustrated and agitated.

13. Mr Y had been admitted to the Old Rectory in late summer 2019. He came from hospital for interim care while he was assessed, and funding arranged. In November, the Council agreed funding for him to remain there as a long term resident. At the initial review in December, the Council noted family were satisfied with the placement and the Council planned to review Mr Y in one year.

14. Around one year after he arrived at the Old Rectory, in late summer 2020, Mr Y was unexpectedly admitted to hospital. The Council received a referral from the hospital saying that, due to concerns about the care he received at the Old Rectory, Mr Y needed a change of care home. The Old Rectory was outside the Council's area, so the safeguarding enquiry was carried out by the council responsible for that area, Council B. The safeguarding officer from Council B told the Council that enquiries were still underway but in view of the injuries sustained, Mr Y should not return to the Old Rectory. The Council arranged another placement for Mr Y, and he went there following one week in hospital. Mr Y sadly died a few weeks later.

15. The Care Provider commissioned an independent investigation which found that Mr Y laid on his right side, in the same position for at least 13 hours without repositioning. He may have been in that same position for up to 24 hours without repositioning and his skin was caused substantive injury. It found Mr Y was caused serious but unintentional neglect/gross negligence due to the failure to comply with his care plan. The investigation concluded that staff genuinely cared for Mr Y's wellbeing and tried not to disrupt his rest but did not follow his care plan. Staff also failed to give Mr Y appropriate food or drink and did not identify or address his injuries in a timely manner. The report recommended disciplinary proceedings. The Care Provider also self referred to CQC.

16. Mrs X complained to the Care Provider and then to us. The Council was not aware of the complaint until this point. Mrs X told me there had been a few issues during Mr Y's stay in the Old Rectory, but they were all sorted out. However, she said it all started to go wrong when the first COVID-19 national lockdown began.

17. In November, the Care Provider wrote to Mrs X with "unreserved apologies" and said it was "taking steps to ensure that nothing like this happens again at one of our care homes" including:

    - An internal investigation and disciplinary procedures in respect of at least four members of staff, two of which have already been suspended.
    - A comprehensive review of policies and procedures to ensure as far as possible they reflect current best practice.
    - Strengthening supervision and training processes for all carers and providing additional training and supervision where necessary.
    - Updating the requirements of staff handover processes to implement any changes to policies and procedures.

18. In May 2021, Council B wrote to Mrs X. it set out what had happened with the safeguarding enquiry and the findings of the independent investigation. The letter said it had advised "relevant regulatory and commissioning bodies" of the safeguarding enquiry outcome. It also said: "appropriate and proportionate actions were taken to mitigate the risk to others". Council B apologised to Mrs X and said it did not provide her with the standard of service expected in dealing

with her correspondence. It also apologised that it did not ensure she was updated about the safeguarding enquiry.

Mr Y's care records

19. Aside from the issues relating to the events leading to Mr Y's hospital admission in late summer 2020, Mr Y's records contained numerous body maps. Most of these are unremarkable and showed regular but minor skin tears and bruises. However, some show more significant injuries. A series of injuries over one week in January 2020 included "sore tops of toes" on both feet, bruising to upper arms and head, a small cut and a bump to his head. Then again, in July, bruising to head, knees and hips and at least two skin tears thought to relate to a fall in mid July. The bruising to his knees was on the left side and the bruising to the head and hips, was on the right side. In early August, bruising to his head, top of his back and skin tears on his elbows. There were no accident/incident reports or evidence that the Care Provider had reported these injuries as Mr Y was on blood thinning medication and had injuries to the head. There was also no evidence that care plans or risk assessments were reviewed in light of these incidents.

20. The MUST screening tool was completed monthly until February 2020 then not until June and again in August. Mr Y was to be weighed daily at the request of the "heart team" from May 2020. By July Mr Y was not weighed on several days and there were no records at all during August or September.

21. On admission, the Care Provider assessed Mr Y as at high risk of pressure sores. The risk assessment was reviewed every 4-6 weeks until February 2020. After this, the next review was June when Mr Y was found to be at 'very high' risk and then August which was also 'very high'. Mr Y's care plan for pressure ulcers had last been reviewed in March 2020 by the district nurse who noted the dressing could be left off. However, the independent investigator found Mr Y had existing pressure sores, so this suggests there was no up to date care plan for this. Mr Y's falls assessment was similarly reviewed monthly to February 2020 when the risk was 'medium'. It was next reviewed in June when the risk had increased to 'high' and then August, also 'high'.

22. Mr Y's care plans and risk assessments included the following comments relating to the events leading to Mr Y's hospital stay in late summer 2020:

General monitoring

23. To monitor Mr Y for any signs of deteriorating health.

24. Carer responsibility for identifying pressure damage, photographing, cleansing, applying dressing and phoning district nursing service for advice. Also, to initiate 2 hourly turn schedule and off load heels if appropriate.

Overnight

25. Regular checks throughout the night.

26. Staff to check Mr Y regularly throughout the night.

27. Mr Y repositions himself at night as he moves around and gets up a lot.

28. Requires repositioning overnight with 2.

29. Staff to offer assistance to the toilet when Mr Y wakes in the night.

30. Staff to encourage fluids and offer something to eat when Mr Y wakes in the night.

31. “Staff to use a slide sheet to reposition [Mr Y] during the night if he is in the same position as the last check to protect his skin”.

Equipment

32. Electric profile bed with integral bed rails – risk of trapping limbs/neck/bruising/rolling over top of rail.

33. Movement sensor box to be placed in Mr Y’s bedroom next to his bed.

34. “Staff to ensure [Mr Y’s] sensor box is working every time they leave his bedroom as it alerts staff to [Mr Y] moving and he is unable to use the call bell”.

35. Rising from the floor – hoist needed.

The events leading to the safeguarding concerns and hospital admission

36. Staff found Mr Y in his room with injuries including:

- Injured and bleeding toe and toenail.
- Pressure sores.
- Swelling along right side from head to toe.
- 23 skin tears on his body.
- High temperature.
- Possible dehydration.

37. The previous day, Mr Y had not eaten, drunk, or taken any medication because he had slept from early afternoon until 9:30pm. Staff raised a concern about this when handing over to the night staff. Mr Y woke soon after this and shouted. His motion sensor either became faulty, or was switched off, around this time. Staff found him distressed and laying on his right side facing the wall. They gave Mr Y some medication he had missed earlier to help him settle. Mr Y’s foot had become lodged between the bed and the wall. Staff lifted his feet out and noticed traces of blood on the sheets, a grazed and damaged toe nail which did not need any attention. The night team checked Mr Y regularly and had no concerns. Mr Y stayed in the same position all night and staff did not reposition him, managing to change his pad at 4am without repositioning.

38. The night staff handed over to the day staff telling them of the injury, and that they should check on him. At 8am, staff went to Mr Y’s room and noticed the motion sensor was off. They switched it back on. At 10:30 Mr Y needed his pad changing and staff moved his bed away from the wall so he could easily be repositioned and noticed blood trailing down the wall and pooled on the floor. When they turned Mr Y onto his back, they found other injuries. Staff called the emergency services and paramedics attended to Mr Y’s injuries. Staff said they did not know how these had happened. They discounted a suggestion that Mr Y had fallen because he would have needed two staff to lift him back onto his bed. His care plan says a hoist would have been needed to raise him from the floor. The Care Provider alerted Police who also attended. Mrs X says it was the paramedics who alerted the Police.

39. When Mr Y was admitted to hospital, staff raised a safeguarding concern because:

- He had 20 injuries, including skin tears, that could be consistent with being dragged, pulled or lifted back into bed.
- Staff at the Old Rectory had not recorded a fall.

- Mr Y was on blood thinning medication and staff at the Old Rectory should have sought medical attention at the time the injuries were sustained.
- Possible fall from bed and put back into bed but day staff not alerted. The ambulance crew said Mr Y had been lifted by care workers – marks/skin tear under right arm and grazing to face.
- Friction burn to his right shoulder.
- Toe nail was mostly removed.

40. The Police later concluded there was not enough evidence that a criminal offence of neglect had been committed and said the Care Provider could investigate. The Council responsible for the area agreed to that and its safeguarding enquiry oversaw the investigation by the independent investigator which began in October.

Was there fault which caused injustice?

41. The Care Provider accepted it was at fault in the way it provided care to Mr Y. This caused Mr Y significant and avoidable harm and failed to provide him with the care he needed. From the records, I have concluded that Mrs X's view that it all started to go wrong from the first COVID-19 national lockdown is, on the balance of probability, right. The critical assessments around pressure sores, weight, and risk of falls, were not completed from March until August. This means we cannot be confident that Mr Y received the care he needed over this time. The incident in late summer 2020 that lead to his hospitalisation, demonstrates the importance of staff keeping, and adhering to, accurate and up to date care plans.

42. Mrs X and Mr Y's family received conflicting information and had difficulty understanding what had happened. Some of this was due to the nature of the concerns and that nobody appeared to know what had happened. Some of the confusion was due to a lack of communication between the Council, the Care Provider, and Council B. While the Council was not aware of Mrs X's complaint, it became aware of the safeguarding concerns while Mr Y was in hospital. It contacted Council B to confirm the need to move Mr Y to another home. It should also have followed up on the safeguarding outcome to understand what had happened to Mr Y so it could provide support to Mr Y and his family.

43. This was also a significantly distressing and traumatic experience for Mr Y's family, especially for Mrs Y who felt the responsibility for Mr Y being in the Old Rectory. This continued over several months during which they tried to find out what happened. We are not able to provide a complete explanation for these events, but I am satisfied that this has now been done as far as possible.

44. Once Mr Y's injuries were noticed, the Care Provider acted properly in calling the emergency services and engaging an independent investigator when asked to investigate. It has given a meaningful apology to the family and has taken steps to stop similar problems happening in future. This is to be commended. However, I have identified potential breaches of regulations 9, 12, and 17 so will share a copy of the final decision with CQC although CQC has already been involved. I should also note the difficult and challenging circumstances for care providers especially around March 2020 and the following months. However, regardless of the challenges, Care Providers are still required to comply with regulations and provide people with safe care.

45. I have not recommended any actions relating to others who may be at risk; this has been considered by the safeguarding enquiry. The Council is not responsible

for monitoring the quality of the Old Rectory, but this has also been covered by the safeguarding enquiry and CQC notified. CQC will now receive a copy of my final decision so this will also provide further evidence to inform their activity with the Care Provider. I have therefore not seen any reason to extend my investigation and I am sufficiently satisfied that appropriate actions have been taken to avoid similar problems in future.

46. Although the Care Provider has already given a suitable apology, Mrs X says she has not seen this. The Council should now provide a further apology to properly conclude the complaint.

47. Usually, in circumstances such as this, I would recommend reimbursement of care costs, and payments in recognition of the significant distress caused to Mr Y's family. However, Mrs X says they do not want any financial remedy, they only want to make sure no one else has a similar experience.

Agreed action

48. When a council commissions another organisation to provide services on its behalf it remains responsible for those services and for the actions of the organisation providing them. So, although I found fault with the actions of the care provider, I made recommendations to the Council.

49. To remedy the injustice caused by the faults identified above, I recommended the Council:

- Arrange for the Care Provider to provide a suitable apology to Mrs Y.
- Apologise to Mrs Y and Mrs X, setting out the faults identified above and the actions taken, or to be taken, to address these, including the actions taken by the safeguarding authority.
- Ensure that, when a safeguarding enquiry involves someone placed by the Council, it follows up to ensure it is involved where appropriate. It should also ensure it receives information about what happened to the person to enable it to properly support the person and their family.
- Complete these recommendations within one month of my final decision and provide evidence to me. Suitable evidence would include a copy of the apology letter and details of the actions taken to complete the second recommendation.

50. The Council has agreed to complete these actions.

Final decision

51. I have completed my investigation and uphold Mrs X's complaints about the residential care commissioned by the Council for Mr Y.

Investigator's decision on behalf of the Ombudsman

14 October 2021

Complaint reference:
20 012 648

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Mrs X complained about the Council's decision that she did not qualify for an offer to use Short Breaks funding for her daughter that could not be used because of the COVID-19 pandemic to buy equipment for her instead. The Council asked Mrs X to pay the money she spent back into the fund. We have found some fault in the information provided about the scheme and in the way the Council considered Mrs X's case. The Council has agreed to allow part of the payment she made to be covered by the scheme.

The complaint

1. In November 2020 the Council offered families the chance to use Short Breaks funding they received but could not use because of the COVID-19 pandemic to buy equipment for their children instead. Mrs X complains that when she did so the Council unfairly told her she was not eligible. She says she understood from the information she received about the offer that she would be eligible. The Council is now refusing to authorise the payment and asking her to pay the money she spent back into her daughter's direct payment account.

The Ombudsman's role and powers

2. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***

3. If we are satisfied with a council's actions or proposed actions, we can complete our investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

4. I discussed the complaint with Mrs X and considered the information she provided. I considered the information the Council provided in response to my enquiries. I considered relevant law, guidance and policy on council support for children and young people with disabilities during the pandemic. Mrs X and the Council had an opportunity to comment on my draft decision. I considered any comments received before making a final decision.

5. Under the information sharing agreement between the Local Government and Social Care Ombudsman and the Office for Standards in Education, Children's Services and Skills (Ofsted), we will share this decision with Ofsted.

What I found

Short breaks funding

6. The Council's Short Breaks service offers short breaks to families of children and young people with disabilities to give the carer a break from caring, and give the child or young person the chance to take part in activities. The Council may provide the support through direct payments to the family, for example to employ a Personal Assistant (PA). Or it may commission a service itself, or there can be a mix of the two.

Impact of COVID-19

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

8. The government issued guidance in April 2020, updated in August and November 2020, for councils, clinical commissioning groups (CCGs) and families about providing and receiving direct payments. This advised that councils and CCGs should take a flexible approach to arrangements for people receiving all forms of direct payments so they could continue to meet their care and support needs during the pandemic.

What happened

9. Mrs X has a daughter, D, who attends a specialist school. She receives funding for Short Breaks. This is delivered partly through direct payments to pay for a PA to take D out, and partly, since October 2020, through D attending a support group at a centre.

10. In June 2020 the Council offered families whose Short Breaks services had been disrupted because of COVID-19 the chance to use £150 of their allocated fund to make a one-off purchase. Mrs X did not take up the offer.

11. In November 2020 the Council reviewed the support it was providing to children and young people under the Short Breaks service during the pandemic. It decided to extend its offer. It wrote to special schools with details of the offer. On 23 November Mrs X received an email from her daughter's school about the new scheme. The email said an officer from the Council's Short Breaks service had asked the school to give her the information. There was a link to the relevant page of the Council's website and an information sheet attached describing the offer. The information sheet included the following information.

- The Council was aware that a significant number of children and young people had not been able to access their usual Short Break provision for various reasons because of COVID-19.
- This could be because: PAs were not available; families were shielding; Short Breaks providers could not continue the same level of support; or families could not spend direct payments on activities.

- The Council was now offering families who could not use their Short Breaks allocation an opportunity to buy equipment and toys so they could continue to support their children's development.
- *"This offer is only available to children or young people who are known to the Short Break service and have been allocated Short Break hours and have them as a direct payment for activities only, or families unable to use their Personal Assistant (PA) or Provider Service due to them being unavailable as a result of Covid-19*."
- *"Hours will not be able to be transferred from PA or Provider Service agreements if the PA or Provider Service is still offering support."*
- *"If you currently use your Short Break allocation through a PA or Provider Service and they have informed you they are unable to offer support due to Covid-19, you are eligible to take up this offer".*

12. The information sheet explained how parents could take up the offer. The conditions included the following.
    - Parents could use the direct payment money to buy an item for their child, as long as they had sufficient funds in the current year's account.
    - Any money spent would be deducted from the current Short Breaks allocation.
    - They must complete the purchase by the end of January 2021.
    - *"All items must be purchased from a reputable retailer (including online retailers)".*
    - Parents may contact the Council to ask for a pre-paid card and may use their own money to purchase items in the meantime. They could then reimburse themselves from the card when they received it.
13. Mrs X says when she received this email D had not been able to see her PA for a total of around 12 weeks since the start of the pandemic. This was because of various periods of self-isolation for either Mrs X's family or the PA's. Mrs X had also received an email around ten days earlier saying the centre D attended for her group session was temporarily closed because of COVID-19.
14. Mrs X understood she would be eligible for the Council's Short Breaks offer. She used her pre-paid direct payments card to buy two items for a total of around £600. The first was equipment to help take D out for outdoor activities, bought second-hand from someone she knew. The second was equipment to help with producing educational materials, bought online from a well-known website.
15. In early January Mrs X wrote to the Council to say she had used the offer due to D's PA *"being unable to work intermittently through Covid".* She referred to the items she had bought. She said she had since re-read the criteria and wanted to double check that the second-hand purchase was covered as it was from a private seller.
16. The Council replied saying D was not eligible for the offer as payments had been made to her PA and she had attended the group sessions.
17. There was further correspondence between Mrs X and the Council over the next few weeks including a formal complaint from Mrs X and the Council's responses. The Council continued to maintain that D was not eligible for the offer and Mrs X disputed this.
18. In the course of this correspondence the Council said:

- The offer was *"only available to families who are receiving no support at all"* or *"have had no support through lockdown",* whereas according to Mrs X D had received intermittent support.
- It targeted the offer specifically on families who received their Short Breaks as a direct payment for activities and had no commissioned provision. Many of these had not had access to any activities since March. It was also targeting families where commissioned provision was suspended due to COVID-19.
- There were no exceptional circumstances to justify awarding the offer to Mrs X.
- The November offer only covered the period from that point onwards. Any direct payment hours not used would be carried over to the next year's allocation.
- There was a difference between the first offer in the summer of 2020, which Mrs X did not take up, and the second offer in November 2020. This was to recognise the fact that while some families had been able to access some support since the beginning of the national lockdown, others had received none at all. The second offer was targeted at the latter group. The Council sent out letters to eligible families only, which did not include Mrs X.
- In any event one of the items Mrs X purchased did not come from a reputable retailer and so the Council could not approve it.
- As she was not eligible she would have to repay the money she spent.

19. Mrs X's view was:

- The information she received did not say the support had to be continuously unavailable, or that the offer only applied to those who had received no support at all. Her daughter had missed out on over 12 weeks' support from her PA and some of her group sessions had been cancelled.
- She received the information about the offer from her daughter's school with an email saying the Short Breaks officer at the Council had asked the school to give it to her. It did not say the Short Breaks team would contact her directly. There was nothing to indicate the second offer was targeted at families with different circumstances to those in the summer offer.
- She accepted she should have clarified whether the items she bought would be covered. However if the Council had responded to her earlier she would have had an opportunity to return the item, but it was too late to do so now.

20. In its final response the Council did not accept it was responsible for the situation where Mrs X could not return the item she had bought. It said it responded to her immediately with its decision that it would not approve the spending. It confirmed she would have to repay the money within 30 days, or arrange a repayment plan.

Analysis – was there fault causing injustice?

21. Looking at the information the Council provided in November 2020, I agree with Mrs X that it does not make it clear that the offer applied only to families who had received no support at all through their Short Breaks funding during the pandemic. It referred to children and young people who had not been able to access their 'usual provision' and gave the example of providers who could not deliver the 'same level of support'.

22. In my view it is understandable that Mrs X believed she might be eligible for the offer. She received the information the Council had produced about the scheme

from D's school with a message that the Council had asked the school to pass it on to her. She had no reason to think she was not part of a targeted group.

23. If the Council had intended to make the offer available only to families who had received no support at all during lockdown, it should have made this clear. I consider the failure to do so was fault.

24. However I agree with the Council that there were two parts of the message that were clear. The first is that the offer would not apply if the PA or provider was still offering support. In this case Mrs X has provided evidence to show that when she received details of the scheme in November 2020, the centre D attended for her group sessions was temporarily closed. So I consider she satisfied this condition and that the Council's failure to consider this matter properly is fault.

25. The second is that the offer would only cover items bought from a reputable retailer. Mrs X had doubts herself that the scheme would cover the second-hand item she bought. It is clear that it would not.

26. When Mrs X wrote to the Council in early January 2020 to check whether the second-hand item would be covered, the Council replied the same day to say she was not eligible. Although the Council gave different explanations as the correspondence went on, it did not change its decision. So I do not accept that delay by the Council prevented Mrs X returning the items and getting her money back.

27. For these reasons, and in the spirit of the government advice about flexibility in the use of direct payments during the pandemic, my view is that the Council should treat Mrs X as qualifying to have part of her payment covered under the Short Breaks offer.

Agreed action

28. I recommended that the Council treat Mrs X as covered by the November 2020 Short Breaks offer for the cost of the item she bought online. It should approve this payment and not ask her to pay the sum back into D's Short Breaks fund. Although the Council does not agree the information it provided about the scheme was unclear, it has agreed to this recommendation.

29. Mrs X will need to provide proof of purchase. The Council should complete this action within one month of the final decision on this complaint.

Final decision

30. I have found some fault by the Council causing an injustice to Mrs X. The Council has agreed a suitable remedy and so I have completed my investigation.

Investigator's decision on behalf of the Ombudsman