02 November 2020

Complaint reference:
19 006 810

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Ms C complained about the temporary care her (late) father received in a nursing home, which was commissioned by the Council. The Ombudsman found there was fault with the care Mr F received, and the way in which the care provider responded to Ms C's complaint. This resulted in distress for which the Council has agreed to apologise and pay a financial remedy.

The complaint

1. The complainant, whom I shall call Ms C, complained to us on behalf of her (late) father, whom I shall call Mr F. Ms C complained about the residential respite care the Council arranged for her father between 3 and 14 February 2018. She complains that:
   - The home failed to provide the care her father needed for a pressure sore.
   - The home failed to puree his food and did not provide him with 'fork mashable' food.
   - The home failed to weigh her father and monitor his weight, as required.
   - The home failed to empty her father's catheter bag on time.
   - The home failed to properly process / deal with her complaint
2. Furthermore, Ms C complains the Council failed to share the findings with her from its safeguarding investigation into the above concerns.

The Ombudsman's role and powers

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

5. 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

6. I considered the information the information I received from Ms C, the Council and the NHS Tissue Viability Nurse service. I shared a copy of my draft decision statement with Ms C and the Council and considered any comments I received, before I made my final decision.

What I found

Mr F's pressure sore care

7. Ms C says her father had a pressure sore, which did not improve at home. As such, the district nurses advised that he should temporarily go into a care home so he could be turned every two hours, throught the day and night. The stay would therefore hopefully improve his moisture lesion.

8. Mr F went into Greenacre Grange nursing home (run by Horizon Care (Greenacres) Limited) on 3 February 2018. On that day, the affected area was described in the home's records as 3 by 1 cm. Ms C says she explained to the home at the pre-admission assessment, how his wound should be cared for. The home was supposed to treat the sore/wound twice a day and turn him every two hours. However, Ms C says the home failed to do either. Ms C told me the home failed to turn him every two hours, because family members were there for hours during which the home did not turn him. She also said that family members left a towel rolled up at the side of him at night and saw the next morning that it hadn't moved. She said the family did this to see if staff repositioned her father at night.

9. Ms C also told me that:

- Her father's wound wasn't treated with cream for the first five days.
- The home did not use sterile water and washed the open wound with tap water and toilet paper instead. The family witnessed this on one occasion and the nurse told them the home did not have sterile water. When her father was at home, he was prescribed sterile water, which the nurses always used to wash him.
- Furthermore, the family noticed that her father's air flow mattress was deflated on two occasions.

10. Ms C says that, as a result of the above failings, the moisture lesion deteriorated and became a level 3 or 4 pressure sore when the family took him back home after eleven days.

11. The home's Risk Assessment (pressure sore) states:

- Risk of developing pressure sores due to Mr F's poor condition, he is bed bound and unable to turn himself in bed.
- Medical Condition and Associated Risks:
    1. Requires regular turns 2-hourly.
    2. Ensure air mattress is in place.
    3. Ensure air cushion is in place for the chair.

4. Check the skin integrity regularly and apply creams to sacrum and dry areas
5. Incontinent of faeces. Ensure skin is well cleaned and dried properly following episodes of faecal incontinence.

12. The home's care plan "Skin Integrity" added that:

- Staff to check Mr F's pressure areas at least daily and report any concerns to the Nurse on Duty
- Refer to Tissue Viability Service if needed

13. Ms C says:

- Her mother spoke to the care home's nurse on 3 February 2018, the day of Mr F's admission. The nurse said the home did not have 'stuff to treat her father's wound'. Her mother said the family would bring pro shields cream the next day.
- The family brought the cream the following day. She told the carers and put it in his room under the 'medication cupboard', so the nurse would see it when coming in; "you couldn't miss it".
- Ms C says the family noticed on 5 February that the cream had not been moved. A nurse told her on 6 February that she had not seen the cream. By that time, his wound looked awful and had tripled in size. Ms C says it was washed and creamed three times a day at home.

14. The Council told me that a photo dated 5 February 2018, confirmed the wound was a moisture lesion. A record from 6 February said the home's nurse reported that a District Nurse was continuing to visit to monitor the moisture lesion. However, the local NHS Trust told me that district nurses did not visit the home during Mr F's stay, because he was in a nursing bed which meant the home's own nurses could provide any care required.

15. At a joint meeting on 6 February 2018, when pro shields was discussed, the record states that Ms C reported that her father had used this previously and found it to be very good in treating the sore. The record does not mention that Ms C reported any concerns at the meeting to the home or the social worker about the way the home had managed the affected area so far.

16. On 7 February 2018, Ms C witnessed that a staff member cleaned her father's affected area with normal water and toilet paper, rather than with sterile water. The District Nurse has since told the Council that if the wound was a moisture lesion, staff would not have had to use sterile water. At the meeting the previous day, the wound had been described as a moisture lesion.

17. The Council told me that the care home's records showed there are regular recordings by the care and nursing staff, that show they attended to Mr F throughout the day and night. It said that whilst the records did not always state the support provided was for pressure care, they evidenced that staff attended to Mr F at least every two hours. The notes also include several recordings that suggested staff applied barrier cream and changed dressings.

18. The care home's records state that:

- 4 February 2018
    1. There is no record in the morning to show if/that night staff turned Mr F every two hours.
    2. 4pm: "*2 hourly positional changes performed*".

- 5 February
    1. 6am: "*Pressure area care was met by staff*".
    2. There is no record in the afternoon / evening to show if/that day staff turned Mr F every two hours.
- 6 February
    1. 5am: "*Pressure area care was met by staff*".
    2. 7pm: "*Regular turn. Sacrum area grade 1 to 2. Medication given as prescribed*".
- 7 February
    1. 5am: "*Barrier cream applied. Pressure relief maintained*".
    2. 4pm: "*Seen by Practice Nurse. Continue with barrier cream. She will discuss with GP if dressings are needed*". No information about being turned by day staff regularly
- 8 February
    1. 7am: "*Pressure area care maintained*".
    2. 8pm: observation about the status of the wound. No information about being turned by day staff regularly
- 9 February
    1. 7am: "*Pressure area care was met by staff, turns were maintained*".
    2. 7pm: No information about being turned by day staff regularly. *"Sacral wound photographed and sent to Tissue Viability Service. Wound redressed as per plan"*. The TVN says it received a referral asking for treatment advice for category 2 pressure ulcer.
- 10 February: No records of what happened.
- 11 February
    1. There is no record in the morning to show if/that night staff turned Mr F every two hours.
    2. 2 pm: *He remains in bed. Dressing renewed. Had all his medication.* No information about being turned by day staff regularly.
- 12 February
    1. 7am: Pressure area care was met by staff. Dressing intact and clean.
    2. *TVN responded to referral. Telephoned and spoke to the agency nurse in charge of the shift that day. The nurse advised that the patient had a category 2 pressure ulcer to the sacrum and assured RL that the patient as nursed on an alternating airflow mattress and was being repositioned on a 2-hourly basis. The nurse could not comment on the wound's appearance. TVN arranged a joint appointment with the care home for 14 February 2018 and advised the agency nurse upon assessing the wound, if they felt the visit was more urgent to contact the Tissue Viability Service prior to the visit.*
    3. There is no record in the afternoon / evening to show if/that day staff turned Mr F every two hours.
- 13 February: No information about turning etc

- 14 February
    1. 5am: "*Turned two hourly last night and during the day*"
    2. The home did not provide a record that shows what was discussed during the TVN visit.
    3. NHS record: *Was informed on arrival that the patient was returning home. Patient's wife was present during the visit and expressed her concerns about the care her husband received at the home and that she was taking him home earlier than originally planned as a result. TVN confirmed the wound was a category 2 pressure ulcer with a combination of moisture. The patient's wife advised TVN, that the patient has an alternating airflow mattress and high-risk cushion at home and normally sits out. The patient's wife advised TVN that she used Proshield Foam cleanser and proshield plus barrier cream at home with good effect. She expressed to TVN whilst in the home, the patient spent all his time in bed and proshield plus barrier cream had not been applied for several days. The recommendations provided by TVN was to continue with the proshield foam cleanser and pro-shield plus barrier cream. TVN asked the nurse at the care home to refer the patient to the Community Nursing Team for support at home and advised the patient's wife that they will refer to the Tissue Viability Service again if they felt they required any further advice. Patient was then discharged from the Tissue Viability Service".*

19. Ms C says that, by the time the TVN checked her father's sore on 14 February 2018, the wound had become a grade 3-4. After the visit, the family took Mr F out of the home. The care home told the Council the following day that the TVN confirmed that the pressure area had improved. However, there is no evidence that shows the TVN said this.

20. A District Nurse spoke to the Council on 2 March 2018. The record states the lesion was a grade 3 pressure sore now. The family had shown the nurse a photo of the area from the date he returned home and reported it had improved since then.

21. The care provider responded to Ms C's complaint in June 2018. It said that:

- Assessments and plans of care were in place for Mr F's pressure area care. The daily care records show the care to his pressure area has been documented. It also shows that appropriate steps were in place to care for his pressure area, including dressing changes, barrier creams and referrals to visiting professionals.
- Visiting professionals were involved with Mr F's pressure sore care whilst he was at the home and made decisions about his treatment.
- Whilst there was a deterioration of the area, the home took appropriate action, including seeking (and acting on) advice from external specialists.
- The family did not raise any issues about Mr F's mattress. However, it accepts the mattress was not fully inflated on two occasions. It appears this was because a tube was disconnected from the machine, for which the home would like to apologise.

22. The care provider has since said that, at the time of Mr F's admission, it did not receive evidence that barrier cream had been prescribed to be used for Mr F.

23. The Council has since said that the care home's pre-admission assessment should have discussed and highlighted, before Mr F's admission, what medication and creams he needed. The home's service user guide has been updated in the section on respite care.

Analysis

24. The only reason for Mr F's stay at the home was to improve an affected skin area. He was also recorded as high risk for pressure sores developing. As such, I would have expected the care home to keep detailed records of the care it provided to Mr F's affected area. Detailed records are also important to enable senior staff / managers at the home to monitor that staff are implementing the care as per the care plan and assessments. However, I found that:

- Although there were some records that described the affected area, overall there was a lack of detail in terms of describing how the affected area looked and changed (compared to the day before)
- There were some general references about pressure care "having been met". However, there were many instances when there was no record at all as to what (if any) pressure care was provided.
- There is no actual evidence that shows at what times throughout the day or night Mr F was actually turned.
- The home's risk assessment (pressure sores) says that staff should regularly apply creams to sacrum and dry areas. There is no evidence this was done during the first five days of his stay and/or that the nurse had decided this would not be necessary. Furthermore, there is insufficient evidence in the home's records to conclude how often this was subsequently done throughout the day.

25. Ms C also mentioned the home kept Mr F in bed "all the time", which increases the risk of deterioration, even though he would be taken regularly out of bed at home. She also said the family observed staff failing to turn Mr F during visits.

26. However, according to the records (including those from the NHS), the pressure sore was grade 2, not grade 3 or 4, when Mr F left the home.

27. As a result of the above, I am unable to conclude the care home managed Mr F's affected area in line with its risk assessment and care plan. As such, I have found that the home failed to provide the pressure area support Mr F needed during his stay, which may have contributed to a deterioration of the affected area.

28. I have not seen evidence that shows that, considering the stage the affected area was at the time, that staff should have used sterile water.

Mr F's dietary needs:

29. Ms C said that:

- When her father's dementia deteriorated, he would constantly just chew his food without swallowing. The family therefore started to blend his food.
- Her father did not have capacity to make decisions about the texture of his food. As such, the family told the home at the pre-admission assessment that her father could only eat (swallow) fork-mashable food. The assessor told the family this would not be a problem.
- However, the home failed to do this. The family visited Mr F about two to three times a day, and especially at mealtimes. The family regularly raised a concern

that Mr F did not receive this type of food, which the home ignored. This resulted in weight loss.

30. Ms C says the local NHS Trust completed an assessment at the home on 6 February 2018. The form completed said that: *care home to take his weight and monitor*. Ms C says the home received a copy of this form. However, the care home failed to do this. Her father lost nearly 6 kilograms in two weeks.

31. The nursing home's Assessment Report said:

- Mr F has been assessed as not having capacity to make decisions relating to eating and drinking
- He has no difficulties eating - drinking - swallowing or chewing
- Mr F eats and drinks independently. He needs a fork mashable dysphagia diet (modified diet E).
- Mr F's weight will be monitored weekly through the Weight (M.U.S.T) Chart. His food intake will be monitored through the Food chart.

32. The nursing home's care plan "Eating and Drinking" said that:

- Mr F was unable to make choices about food and drink. He prefers to have a fork mashable diet, through choice rather than need. He needs his food cutting up.
- The home needs to initially weight Mr C weekly. If his weight has been maintained after four weeks, he can be weighed monthly.

33. I reviewed a print out of the care home's electronic care records, which showed that Mr F did not receive fork-mashable food for lunch and dinner. However:

- He ate most of his breakfast most of the time.
- He ate half (or less) of his lunch on five occasions.
- He ate half (or less) of his dinner on six occasions.
- He had pureed food four times

34. Ms C told me the records are not true as he never ate his meals.

35. The care provider told Ms C in June 2018 that:

- The staff assessed that Mr F did not have any difficulty with swallowing or chewing. He did have difficulty in cutting up food, so staff recorded it would cut his food for him.
- A Texture Modified Diet is usually recommended by a professional (such as a Speech and Language Therapist), because providing one when there is no difficulty in swallowing can sometimes increase the risk of choking.
- The records show Mr F was able to eat a normal diet without difficulty and often ate everything (or at least a significant part of his meals). This did not cause any swallowing or choking issues. As such, it was safe to provide him with normal textured food.
- However, the staff team should have discussed this with the family before, or at the time of, Mr F's admission, so his preferences as well as his safety could have been met. I apologise if this did not happen in your case.

36. Ms C told me that staff did not cut up her father's meals.

37. The care provider also said that: There was no need to formally monitor Mr F's weight, because he was a temporary respite client. As a result, it is not possible to verify if he lost weight during his short stay at the home. The provider considered the photos Ms C sent but could not conclude it showed significant weight loss.

38. The Council says:

- It has not been able to find any evidence in Mr F's medical records that he should receive only pureed food or only mashable food, or that he had difficulty with swallowing.
- If a family says a resident needs a pureed diet, it would be normal process to follow this in cases of short periods of respite. If staff identify a problem, they should involve professionals (SALT etc).
- The home should have done more, on admission, to find out from the family why Mr F was on a pureed diet. This should have been discussed and dealt with at that time.
- Mr F's weight should have been documented on admission. His weight should always have been reviewed one week later (as per plan) and documented.

Analysis

39. The care home has acknowledged it should have further discussed Mr F's need for mashable food with the family, rather than making a decision not to provide mashable food to him. The care home has already apologised for this, which is a sufficient remedy.

40. However, the daily care records indicate that, although Mr F occasionally refused his food, he ate half or more of his meals, even when many meals were not mashable. The records did also not show there was a clear link between getting mashable food and eating more. It may therefore have been that, to some extent, he simply did not have a lot of appetite at times.

41. I agree with the Council's view that "*Mr F's weight should have been documented on admission. His weight should always have been reviewed one week later (as per plan) and documented*".

The home's alleged failure to empty Mr F's catheter bag on time

42. Ms C says the home failed to empty her father's catheter bag on two occasions, as a result of which they started to leak and burst. This resulted in her father's clothes and bed becoming soaked with urine.

43. The care provider told Ms C in June 2018 that her photographs showed there was urine on the floor and bedding. It said the bedding should have been removed sooner and appropriate steps taken to deal with any spillage. The care home said it was sorry for the incident.

Analysis

44. Urine was spilled on two occasions due to an overfull catheter back, which is fault. The care home has already apologised for this, which is a sufficient remedy.

The way the care home dealt with Ms C's complaint

45. Ms C says the care home failed to properly process / deal with the complaint she made. The family made a complaint on 20 March 2018 and was supposed to receive a response by 27 April 2018. Ms C says:

- The family did not receive a response and had to chase the care provider by telephone, and subsequently by email.

- The care provider suggested to meet on 18 May 2018. However, she didn't turn up.
- The care provider met Ms C on 25 May 2018 to discuss her complaint in more detail.

46. It took until 19 June 2018, before the care provider prepared a response. The provider says it sent this to Ms C and her solicitor. However, Ms C says they both did not receive it. I am unable to determine why this was the case. Ms C's solicitor told the care provider on 14 August 2018 that Ms C had not received a response yet. This should have alerted the provider that she did not receive their letter.

47. The director of the care provider met with Ms C on 17 January 2019. After the meeting, the director sent a letter on 29 January 2019 and attached a copy of the June 2018 letter. The letter said that:

- The meeting on 25 May 2018 should have been carried out as a priority, which clearly did not happen in this case. I apologise for the delay in arranging this with you.
- The care provider's response dated 19 June 2018 was sent to Ms C and her solicitor, but not received by either.

Analysis

48. It took two months before the care provider met with Ms C to discuss her complaint in more detail. This was an unreasonable delay.

49. Neither Ms C, nor her solicitor, received the complaint response letter dated 19 June 2018. As such I found that, on the balance of probabilities, this letter was produced but not sent out.

50. Even though Ms C's solicitor told the care provider in August 2018 that Ms C had not received a response as yet to her complaint, there was a further unreasonable delay to respond to this.

51. As a result, it took a long time (10 months) before Ms C received a response to her complaint. The above delays are fault and resulted in distress and frustration to Ms C.

The Council's safeguarding investigation

52. Ms C complains the Council failed to share the findings from its safeguarding investigation with the family, with regards to each of the concerns they had raised.

53. The Council wrote to Ms C on 26 November 2018. The letter referred to a meeting with Ms C on 21 November 2018, during which the Council had shared the findings from its safeguarding investigation with Ms C. The Council said that, at the meeting, the investigator described what she had done, who she had spoken to and the reasons for her conclusion. Some of the issues were difficult to investigate because several staff involved had since left the home. Ms C told the Council at the time that she was thankful for the visit.

54. A further meeting was held on 17 January 2019 between the Council's Quality Management Team, the Care Home and Mr F's relatives, because the family remained unhappy. At the meeting, all the issues were discussed. Since the events, a new management team had been put in place. There was also a clinical lead nurse now in all of the care provider's care homes, so any problems can be looked at immediately.

55. The Council told Ms C on 28 June 2019 that:

- It is clear, from the care provider's responses and the notes from the meeting (between the Council, the care provider and Mr F's family), that some elements of the service were not up to the required standard. The provider has acknowledged and apologised for this. They also made a commitment to improving their practice and put measures in place to check this.
- The Council will continue to monitor the care home and ensure the improvements are sustained, so the home does not repeat the failings.
- The Council would like to offer a goodwill gesture of a £250 refund of the care home fees.

56. The Council says that:

- It is clear in the investigation report and running records that it investigated all the issues Ms C raised.
- The safeguarding investigator and manager provided feedback to the family with regards to all the issues raised. Further feedback was provided during the meeting in January 2019.
- The family did not raise any concerns with Mr F's allocated social worker at the time Mr F was still in the home. There were several contacts with the family during this time but the family did not raise any issues other than that the wound had not healed as well as they would have liked.

Analysis

57. I did not find fault with the Council, who ensured that Ms C and her family received a response with regards to each of the issues they had complained about.

Agreed action

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

59. I recommended that, within four weeks of my decision, the Council should:

- Apologise to Ms C for the faults identified above and the distress these have caused Ms C.
- It should also pay Ms C £400 for the distress caused as a result of the deterioration in Mr F's affected skin area, and the delays in receiving a response to her complaint.
- Assure itself, together with the care provider, that the care home has made the required changes to prevent a reoccurrence of the above failings.

60. The Council has told me it has accepted my recommendations.

Final decision

61. For reasons explained above, I have upheld Ms C's complaint. I am satisfied with the actions the Council will carry out to remedy this and have therefore decided to complete my investigation and close the case.

62. Under the terms of our Memorandum of Understanding with the Care Quality Commission (CQC), I will share copy of my final decision statement with the CQC.

Investigator's decision on behalf of the Ombudsman

3 November 2020

Complaint reference:
20 004 943

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman will not investigate Mr B's complaint about the care his late father, Mr C received or charging for the care. This is because Mr B's complaint is late and there is no good reason for the Ombudsman to disapply the law to investigate it now.

The complaint

1. Mr B says his late father, Mr C, did not have the mental capacity to sign a financial assessment in November 2018 agreeing to pay for his care. Mr B says as Mr C's attorney's the Council should have included him or his brother in discussions about charging and believed Mr B was discharged from hospital to an intermediate or step-down care placement as he had done previously. Mr B says he wants access to Mr C's care records. Mr B says Mr C had poor care whilst he was resident in the home and was discharged without proper medication or paperwork. Mr B says Mr C's estate should not pay the £2256.00 the Council has invoiced for care it provided between 26 November and 24 December 2018 until a package of care was arranged for Mr C to return home.

The Ombudsman's role and powers

2. 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

3. I considered the information and documentation Mr B provided. I sent Mr B a copy of my draft decision and considered his comments on it.

What I found

4. Mr B says the Council initially arranged a discharge from hospital meeting for Mr C without inviting family members or his attorneys. Mr B says it arranged a further meeting but neither he nor his brother could attend. Mr B says other family members attended and were advised at the end of the meeting Mr B would be discharged to an assessment bed awaiting a package of care to be arranged for his return home.

5. The Council says Mr B was discharged from hospital to a care home on 26 November 2018 as a short-term placement while a care package was being

arranged. It explained previously the same year Mr C had been discharged either to an intermediate bed or assessment placement none of which required payment from the individual but on this occasion Mr C was discharged to a care home on a short term basis. The Council said this was discussed with Mr C who agreed and signed the financial form. The Council said the form was undated and will take this up with the worker in question, however, it confirmed case records show Mr C signed it on 26 November 2018. In addition, it says case records show it spoke to Mr B's brother on 6 December 2018 when visiting Mr C and reminded him to return the financial assessment form. It says Mr B's brother said he will speak to him.

6. Mr B says Mr C did not have capacity to sign the form and either he or his brother should have been included in discussions and arrangements for Mr C.

7. The Ombudsman will not investigate this late complaint. Mr B knew of the matters in 2018 and could have come to the Ombudsman sooner if he was concerned the Council were charging Mr C for care he believed should have been free.

8. Mr B says Mr C did not have capacity to decide he should pay for care and has not seen any capacity assessments. The Ombudsman could not say Mr C lacked capacity in 2018.

9. The Mental Capacity Act 2005 says a person must be assumed to have capacity unless it is established that he lacks capacity. A person should not be treated as unable to make a decision:

   - Because he makes an unwise decision.
   - Based simply on: their age; their appearance; assumptions about their condition, or any aspect of their behaviour.
   - Before all practicable steps to help the person to do so have been taken without success.

10. Mr B says Mr C was returned home in a private ambulance on 24 December 2018 with a sore eye and feet, without paperwork and looking dishevelled. Mr B says he contacted the care home and asked for an explanation of what happened but did not receive a call back.

11. The Ombudsman will not investigate this late complaint. The matters complained of are more than 12 months old.

12. Mr B says he could not complain sooner because payment for Mr C's care was deferred until after he died in February 2020 and his property was sold. It was only then the family were able to dispute the charges for care they believe should be free of charge. However, the Ombudsman could not say Mr C lacked capacity to make decisions in 2018 or that he should have had a capacity assessment to determine whether he could agree to pay for his care. I have not seen any evidence that Mr C was discharged from hospital in November 2018 to an intermediate or step-down placement.

Final decision

13. The Ombudsman will not investigate this complaint. This is because the concerns Mr B raises now are more than 12 months old and there is no good reason to disapply the law to investigate now.

Investigator's decision on behalf of the Ombudsman

Local Government & Social Care
OMBUDSMAN

5 November 2020

Ms Jo Kirkby
Team Manager – Complaints and Information Team
Nottinghamshire County Council
Resources Department
County Hall, West Bridgford
Nottingham
NG2 7QP

Your ref:
Our ref: 20 005 683
(Please quote our reference when contacting us and, if using email, put the number in the email subject line)

If telephoning please contact: 0330 403 4627
email address: E.Kennedy@coinweb.lgo.org.uk

Dear Ms Kirkby

We have received a complaint against your Council. I have advised the complainant that we cannot consider this complaint because it relates to an employment or personnel matter. Such matters are excluded from our jurisdiction under schedule 5/5A paragraph 4 of the Local Government Act 1974.

In such cases, our practice is to treat the details of the complaint as confidential to the complainant. However, I am informing you of it for statistical purposes.

Yours sincerely

EKennedy

Emma Kennedy
Investigator, Assessment Team

We will include this complaint in the published figures for the year ending 31 March 2021. We will record the category as: Corporate & Other Services and the decision as:Closed after initial enquiries - out of jurisdiction.

PO Box 4771
Coventry
CV4 0EH
www.lgo.org.uk

6 November 2020

Complaint reference:
19 011 791

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Miss X complains about the Council's handling of a child protection referral about her son. I have completed my investigation. There is some fault by the Council. It should apologise, pay Miss X £450 and take action to improve its service.

The complaint

1. Miss X complains about the way the Council handled a child protection referral about her son. She says:
    a) the Council did not tell her it was assessing her;
    b) her son's case was closed based on inaccurate information about the support he was getting from Youth Offending services; and
    c) the Council did not keep her properly informed and delayed in providing documents she requested.
2. Miss X says the Council failed to make reasonable adjustments for her as a person with dyslexia when making her complaint.
3. She also complains about how the Council handled her data and says that her privacy was not maintained.
4. As a result, Miss X says she and her son have experienced anxiety and distress.

What I have investigated

5. I have not investigated Miss X's complaint about how the Council handled her data. I explain my reasons for this at the end of this decision.

The Ombudsman's role and powers

6. 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)***
7. We normally expect someone to refer the matter to the Information Commissioner if they have a complaint about data protection. However, we may decide to investigate if we think there are good reasons. ***(Local Government Act 1974, section 24A(6), as amended)***

8. 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

9. I spoke to Miss X about her complaint.
10. I wrote to the Council and considered its response along with relevant law and guidance.
11. I referred to the Ombudsman's guidance on remedies, a copy of which can be found on our website.
12. Miss X and the Council had an opportunity to comment on my draft decision. I considered any comments received before making a final decision.

What I found

What happened

13. Miss X's son, whom I shall call Mr Y, was subject to a licence which imposed certain conditions on his activity and behaviour. At the time, Mr Y was under 18.
14. In December 2018, police found Mr Y in a situation which breached his licence conditions. The police told the Council about this under its duty to notify the Council about child protection concerns.
15. In December 2018, a social worker visited Miss X and her son at home to conduct an assessment. Miss X says the Council did not tell her this was an assessment.
16. In January 2019, Mr Y went to court and was recalled to prison for breaching his licence.
17. In February 2019, the Council held a Child in Need meeting. It agreed that Mr Y was a Child in Need. Miss X says she had to ask three times for a copy of the minutes from this meeting.
18. In April 2019, the Council wrote to Miss X. It said that it was closing Mr Y's case because of the high level of involvement from the Youth Justice Team.
19. Miss X says that at the point of the licence breach, Mr Y only saw someone from the Youth Offending Team (YOT) for a few hours a week. She says this cannot be described as a "high level of involvement".
20. Miss X complained to the Council about several issues. The Council responded to her complaint in September and again in October 2019.
21. Miss X was not satisfied with the complaint response and asked the Council to consider her complaint at stage two.
22. In November 2019, the Council told Miss X that it did not consider her concerns as a complaint. Rather, it said she had raised issues about access to records and data.

My findings

The assessment

23. Miss X says the Council did not tell her it was assessing her when it visited in December 2018. The Council says the social worker spoke to Miss X on the telephone to arrange the meeting and explained the purpose of the visit. The

Child and Family assessment (CAF) also records that Miss X consented to the assessment.

24. I find it likely the Council did tell Miss X it was conducting an assessment. In any event, Miss X says she would not have refused the assessment. So even if I were to find fault, there is no injustice to Miss X.

25. Similarly, Miss X says she did not consent to her information being shared with other agencies. The CAF form records her as having agreed to this. However, since the Council was conducting a child protection inquiry, it did not need Miss X's consent to share information. Therefore, there is no injustice to Miss X.

Closing the case

26. The Council closed Mr Y's case to children's services because of the "high level of involvement" of Youth Justice Services. It decided that Mr Y's needs would be met this way.

27. Miss X says this information was inaccurate because Mr Y had only been seeing YOT for a few hours a week prior to his recall to prison.

28. However, the Council decided to close the case after Mr Y had returned to prison. At this point, the Youth Violence and Exploitation Panel and Multi-Agency Public Protection Arrangements (MAPPA) had become involved in Mr Y's case. The Youth Offending Team had indicated that when released, Mr Y would likely be under an intensive supervision order.

29. These are specialist agencies who work with people with offences. It is not fault for the Council to decide such agencies can best meet Mr Y's needs.

Communication and providing information

30. In its letter to Miss X in October 2019, the Council accepted it delayed sending her the minutes of the strategy meeting and a copy of the assessment. It apologised for this.

31. The delay is fault. However, I do not consider an apology to be an appropriate remedy for the injustice caused. This is because Miss X had to make several requests for the information. This caused her frustration and unnecessary time and trouble at an already difficult time. In addition to the apology, the Council should pay Miss X £100 to acknowledge this.

The complaints process

32. The Council's responses of September and October 2019 refer to Miss X's complaints. Despite this, when Miss X asked the Council to escalate her complaint to stage 2, it told her that her concerns were about information and data. It said her concerns should be dealt with by the Information Commissioner and not the Ombudsman.

33. Miss X had already approached the Information Commissioners Office (ICO). In October 2019, the ICO wrote to Miss X. It said:

"we understand a number of complaints are about the service you have been provided by the council, unfortunately service complaints are not within our remit and we are unable to provide advice on these matters."

34. Although parts of Miss X's complaint were about information and data protection, she had also complained about the service the Council provided her and her son. Furthermore, the Council had already dealt with Miss X's concerns at stage one as a complaint. Miss X's confusion and frustration at the Council then telling her she hadn't in fact made a complaint at all is understandable.

35. It was fault for the Council not to deal with Miss X's complaint at stage two of its complaints process. This caused Miss X avoidable frustration and confusion and delayed her recourse to the Ombudsman unnecessarily. The Council should apologise to Miss X and pay her £150 in recognition of this injustice.

Reasonable adjustments

36. Miss X has dyslexia. She says this makes written communication particularly difficult for her. Miss X says that despite this, the Council required her to make her complaints in writing.

37. In response to my enquiries, the Council said:

"there was no indication from [Miss X] that she had any additional needs, therefore, we were not made aware of the need to make any such adjustments."

38. Miss X says she told the Council during several phone calls about her dyslexia. In August 2019, Miss X wrote in an email to the Council "I did ask for information by [post] instead of email because I have dyslexia". In an email to the Council in October 2019 Miss X said "please don't forget I have dyslexia".

39. By August 2019 at the latest the Council knew Miss X had dyslexia. The Council should have asked Miss X if she needed any reasonable adjustments to access the service. There is no evidence the Council did this. This is fault.

40. The Council's failure to recognise that Miss X's complaint was about both data protection and service provision might have been avoided had it supported her to communicate in the ways she finds most effective. Instead, Miss X struggled to make her complaint understood. The Council should apologise and pay Miss X £200 for the unnecessary additional distress this caused.

Agreed action

41. To remedy the injustice caused by the faults I have identified, the Council should:

- Apologise to Miss X in writing; and
- Pay Miss X £450

42. The Council should take this action within four weeks of my final decision.

43. The Council should also take the following action to improve its services:

- Ensure customers are given the opportunity to identify any reasonable adjustments they might need. For example, by reminding or training relevant staff to include the question at first point of contact.

44. The Council should tell the Ombudsman about the action it has taken within eight weeks of my final decision.

Final decision

45. I have completed my investigation. Fault by the Council caused Miss X an injustice. The action I have recommended is a suitable remedy.

Parts of the complaint that I did not investigate

46. I did not investigate Miss X's complaint about the Council's handling of her data. This is because the Information Commissioner's Office is the body best placed to consider complaints about data protection.

Investigator's decision on behalf of the Ombudsman

9 November 2020

Complaint reference:
19 020 882

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Mr X complained about the processes and information in two child and family assessments the Council completed. He also says the Council failed to ensure his children were suitably educated. The Council was not at fault.

The complaint

1. Mr X complained the Council:
   - interviewed his two children without his consent;
   - falsely stated someone at the children's school had referred to one of the children as 'rough';
   - included inaccurate information about him in a child and family assessment and refused to remove or amend this on his request;
   - did not give him sufficient opportunity to provide the information he considered necessary;
   - revealed to his wife information he had provided in confidence; and
   - failed to provide his children with a suitable school to attend resulting in them being home tutored.
2. Mr X said this has had an adverse effect on his children and himself.

The Ombudsman's role and powers

3. 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)***
4. The Information Commissioner's Office considers complaints about freedom of information. Its decision notices may be appealed to the First Tier Tribunal (Information Rights). So where we receive complaints about freedom of information, we normally consider it reasonable to expect the person to refer the matter to the Information Commissioner.
5. 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

6. I spoke to Mr X and considered his view of his complaint.

7. I made enquiries of the Council and considered the information it provided. This included the family's case file, the child and family assessments from 2018 and 2019 and details of the children's school placements.

8. I gave the Council and Mr X the opportunity to comment on my draft decision.

What I found

Child and family assessments

9. Child and family assessments gather information about the child and their family to make decisions about:

   - whether any interventions are required, and if so, what they should be; and
   - whether the child meets the criteria for ongoing services as a child in need.

10. The 'voice of the child' must be sought as part of the assessment. The Council must seek permission from the parent to speak to the child. If the parent does not give consent, and there are child protection concerns, councils will consider whether to begin safeguarding procedures.

Education Act 1996

11. Section 19 of the Education Act 1996 confers duties on councils to ensure children receive a suitable education:

    "Each local education authority shall make arrangements for the provision of suitable education at school or otherwise than at school for those children of compulsory school age who, by reason of illness, exclusion from school or otherwise, may not for any period receive suitable education unless such arrangements are made for them".

12. Section 7 of the Act confers duties on parents to ensure their child receives a suitable education:

    "the parent of every child of compulsory school age shall cause him to receive efficient full-time education suitable-(a) to his age, ability and aptitude, and (b) to any special educational needs he may have, either by regular attendance at school or otherwise".

13. Education is compulsory. Going to school is not. This means that under s7 of the Act, parents can choose to educate their child at home.

Background

14. This complaint covers events from August 2019 to March 2020.

15. Mr and Mrs X have two primary school aged children, Y and Z.

16. The family has been known to the Council and Police since around 2014 due to alleged domestic abuse. The Council carried out an initial assessment in 2016 and then a child and family assessment in 2017. Y and Z became children in need.

17. The Council closed the case in 2018 when Mrs X said she was no longer in a relationship with Mr X.

Events relating to the child and family assessments

18. In August 2019, following an alleged incident between Mr and Mrs X, the Police were called. As a result, the Council became involved and began a child and family assessment.

19. On 23 September 2019, Mrs X gave consent for the children to be seen at school. A Council child and family assessor visited school to speak to the children and their teachers.

20. The child and family assessment provided details of the family's history. The assessment also contained the following details:

- *"*[Y] *can be rough at times but generally…is settling in well";*
- the children's views of their father, which included a recollection of domestic violence;
- the assessor's view that *"it is concerning the children have an understanding of their father's gambling addiction… this will raise anxieties and instabilities";* and
- Mr X's response to the assessor's views of whether he had a gambling addiction. Mr X strongly refuted this, stating he would spend around £100 a month on gambling and it was a hobby not an addiction. He said it did not have a negative effect on the children because he did not take them into the betting shop.

21. The assessor recommended Mrs X was referred to family services to take part in a support programme. The assessor also recommended the case was closed to children's social care because:

- Mr and Mrs X were again no longer in a relationship;
- Mrs X was working with a woman's aid charity;
- Mrs X had contributed positively to the recent Police investigation into the latest alleged domestic violence incident.

22. The Council carried out another child and family assessment in January 2020. This provided an update on the family's circumstances. It noted:

- Y was being electively educated at home;
- Mrs X had not engaged with the support programme but wanted to work with the Council over the children in need plan;
- Mr X was not living with the family, but Mrs X was in a relationship with him;
- the assessor had concerns that Mr X seemed to be controlling various matters. The assessor cited a report from the Council's elective home school adviser which stated that Mr X wanted all communication regarding the children's education to go through him; and
- the assessor's manager recorded the following comments: *"It is extremely concerning the father does not acknowledge his part in the current concerns… if the child in need plan is not adhered to and there is no meaningful engagement, then consideration to escalate the case should be seriously considered".*

Events regarding the children's education

23. On 12 November 2019, Mrs X made an in-year school admissions application for Y for two primary schools.

24. On 13 November 2019, Mrs X registered Y as being electively home schooled and removed them from school (School S).

25. The two schools refused Y a place stating they were oversubscribed. The Council sent Mrs X a letter informing her of the outcome and advising her how to appeal these decisions. The Council did not make her an alternative offer because by this time Y was being home schooled.

26. An elective home school adviser visited the family on 28 November 2019 to provide guidance about home schooling Y.

27. In February 2020, the parents submitted in year school admissions applications for two schools for both Y and Z. At this time, Z was still on role at a different school.

28. The Council wrote to the parents on 14 February to say there were no places at either school and informed them of their appeal rights. A record from the case files for the same date showed Mr X phoned the Council to say he would be home schooling Z whilst they looked for a school. Mr X said Y was also already being home schooled.

29. Another record from the case file, also from 14 February, stated the Council's home school adviser did not consider the children could be classed as 'home educated' because Mr X wanted them in school and was looking for placements.

30. The Council made the parents an offer for Y of a different school, School S. This was the school Y had originally attended when their parents removed them in November 2019. The parents refused the offer. The Council did not make an alternative offer for Z because they were still on role at their primary school.

31. On 12 March 2020, the parents informed the Council they had removed Z from school.

Events in relation to Mr X's complaint to the Council

32. Mr X initially complained to the Council on 13 November 2019. His complaints were in line with the ones in paragraph 1 of this decision statement.

33. The Council acknowledged Mr X's complaint the same day and then wrote again on 23 November to ask for further clarification of Mr X's complaints. Mr X provided this on 2 December 2019. The Council acknowledged his response on 4 December and said it would not consider his requests to amend the child and family assessments. The Council explained its reasons why and said it would place a copy of Mr X's comments on the file.

34. A Council officer responded to Mr X's complaints on 3 January 2020. In relation to the complaints in paragraph 1, the officer said:

Y was 'rough'

35. The school informed the assessor that Y was 'rough' at times. The assessor recorded this on the child and family assessment.

Consent to speak to children

36. Mrs X had verbally given consent on 23 September 2019.

The assessor's comment that Mr X's gambling had a detrimental effect on the children

37. The officer spoke to the assessor about her analysis of the situation. The assessor was concerned that Mr X appeared to minimise the potential impact of

his gambling on the children and in doing so, had not provided open and honest answers.

38. The officer was satisfied the assessor's conclusions were evidence based and supported her concerns.

Concerns the assessor breached confidentiality when she discussed her conversation with Mr X with his wife

39. The officer said the assessor went to speak to Mrs X after speaking to Mr X, but the assessor said she did not discuss details of the conversation she had just had with him.

The assessor showed a lack of concern for the fact the children were out of education

40. The officer said at that stage the safety and welfare of the children were paramount and the assessor made decisions based on safeguarding matters.

Assessor formed conclusions and wrote a biased report based on a 15 minute conversation with Mr X

41. The officer informed Mr X that the report was based on information provided by third party agencies and conversations with all family members. The officer said it was expected in domestic abuse situations that people would view matters differently.

42. Mr X challenged the outcome of the investigation and asked that it be escalated to stage 2 of the complaint procedures. A Council officer independent of the events reviewed the officer's report and replied on 14 January 2020. The Council upheld the findings of the officer.

43. Mr X complained to us.

My findings

The child and family assessments

44. I have reviewed the child and family assessments from 2019 and 2020 and the case notes for the family.

45. There is no fault in either the procedures followed by the Council or the contents of the assessments.

46. The case notes indicate consent was given by Mrs X on 23 September 2019 for the assessor to speak to the children. This was sufficient. The assessor did not also need the consent of Mr X.

47. The assessor spoke to the school, Mr and Mrs X and the children. The assessor included information relating to ongoing and historic Police involvement, Mr X's gambling, his views and opinions on this together with his views on the domestic abuse allegations and their effect on the children, and the views of the school. All this was relevant and in line with the guidance on child and family assessments. The assessor came to professional judgements, views and conclusions which is what I would expect them to do. These were evidence based and it is clear from the reports what is fact and what is opinion. Mr X disagrees strongly with these views and opinions but that does not mean they are wrong or that the assessor should not have reached them. Further clarification was given by the Council to Mr X in both complaint responses over why the assessor came to their conclusions and all aspects of his complaints. The Council has already told Mr X it will place a copy of his comments on the case file.

48. If Mr X wishes, he can complain to Information Commissioner's Office under the right to rectification if he remains unhappy with this aspect of his complaint.

Education of the children

49. Y had a place at School S. Mrs X removed Y and told the Council she would electively home school them. She was entitled to do so under s7 of the Education Act and the Council was also entitled to conclude it had met its s19 duties. An elective home school officer visited the family shortly after Mrs X made this decision to provide advice. There was no fault in the Council's actions.

50. When the parents decided they wanted Y to be educated at school, the Council processed their in-year school admissions forms promptly and informed Mr and Mrs X of their appeal rights when the schools did not offer placements. The elective home school officer considered the children could not be classed as being home schooled because the parents were applying for school placements. The Council therefore offered Y a school place which his parents refused. It had no duty to offer Z a place at this time because the child was on a school role. There was no fault in the Council's actions.

Final decision

51. There was no fault in the Council's actions. Therefore, I have completed my investigation.

Investigator's decision on behalf of the Ombudsman

12 November 2020

Complaint reference:
20 004 333

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: We will not investigate this complaint about the Council's approval to extend an access driveway. This is because the complaint is late and there are no good reasons for us to consider it now and it is unlikely we would find the Council at fault.

The complaint

1. Miss Y complains the Council has allowed her neighbour to extend the access driveway crossing the pavement to provide access to the neighbouring property. She also complains the Council has not provided her with its policy on dropped kerbs, including the standard measurements used.
2. Miss Y says the approval has led to her neighbours regularly using the access driveway, including at night, when lights shine into her home, disturbing the sleep of her and her family.

The Ombudsman's role and powers

3. The Local Government Act 1974 sets out our powers but also imposes restrictions on what we can investigate.
4. 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)***
5. 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. ***(Local Government Act 1974, section 24A(6), as amended)***

How I considered this complaint

6. I considered the information Miss Y and the Council provided. Miss Y had an opportunity to comment on my draft decision. I considered any comments received before making a final decision.

What I found

7. Miss Y says tarmac was added to extend part of the access driveway leading to her home in July 2019. She contacted the Council and its' contractor in mid-July to complain about the approval, and the extension to the driveway.

8. The contractor responded on behalf of the Council at the end of July 2019. It said the access to Miss Y's property was part of an adopted highway, and not her private land, and for the use of all highway users, including her neighbour. The Council then responded directly in August 2019. It said it had reviewed the access and was satisfied it did not cause a safety hazard. It repeated the contractor's explanation, that the access was part of an adopted highway and said it considered additional vehicle access to properties on a case by case basis. The Council referred Miss Y to the Ombudsman if she wished to pursue her complaint.

9. Correspondence continued between Miss Y, the Council, including one of the councillors, and its contractor from August 2019 until the end of July 2020. She made further contact with the Councillor about the issue in late August 2020. Miss Y approached the Ombudsman in September 2020.

Analysis

10. As Miss Y has been aware of the cause of her complaint since July 2019 her complaint is late. We cannot investigate late complaints unless we decide there are good reasons.

11. Miss Y has not provided any good reasons why she did not complaint to us sooner. Therefore, it would have been reasonable for Miss Y to have contacted the Ombudsman during the 12 months after she became aware of her complaint.

12. The Council properly considered Miss Y's complaint about the approval for access being extended, including ownership of the land, the adoption of the access as a highway and Mrs Y's safety concerns. Consequently, we will not investigate this complaint as it is unlikely the Ombudsman would find the Council at fault.

Final decision

13. We will not investigate this complaint. This is because the complaint is late and there are no good reasons for us to consider it now and it is unlikely we would find the Council at fault.

Investigator's decision on behalf of the Ombudsman

13 November 2020

Complaint reference:
20 003 546

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Mr X complains about the Council's delay in referring a map modification order to the Planning Inspectorate. The Ombudsman has discontinued our investigation. This is because Mr X has asked the Ombudsman to withdraw his complaint as the Council has now referred the matter to the Planning Inspectorate.

The complaint

1. Mr X complains about the Council's delay in referring a map modification order to the Planning Inspectorate.

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 considered the information provided by Mr X.

5. I considered the information provided by the Council.

What I found

What happened

6. A member of the public can ask for a Modification Order to the Definitive Map if they believe, and has supporting evidence, that a footpath or other right of way is shown on the wrong place on the map. This process can also be used to claim that an existing path should be on the map if it is not.

7. The Council must publicise the order and if there are not objections from the public, it is confirmed, and the right of way is added. If it is opposed, the Council must submit the proposed order to the Planning Inspectorate for a decision. There

is no time scale set out in law for when a Council must refer the case to the Planning Inspectorate by.

8. In 2004, Mr X's rambler's association asked for a modification order to the definitive map. The Council made the order in March 2004. The Council received seven objections to the modification order.

9. In 2015, Mr X asked the Council for an update on the modification order. He said the Council told him the case was with its legal team.

10. In August 2020, Mr X complained to the Ombudsman.

11. In November 2020, Mr X told the Ombudsman the Council had confirmed it had referred the modification order to the Planning Inspectorate. Mr X asked the Ombudsman to withdraw his complaint.

Analysis

12. I have discontinued my investigation. This is because the Council has now referred the matter to the Planning Inspectorate and Mr X has requested the Ombudsman withdraw his complaint.

Final decision

13. I have discontinued my investigation.

Investigator's decision on behalf of the Ombudsman

19 November 2020

Complaint reference:
19 020 842

Complaint against:
Nottinghamshire County Council (the Council)

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Mr B complains about how the Council is meeting his care needs and how it has calculated his financial contribution to the care he receives. There appears to be fault in the financial assessment and this has caused Mr B uncertainty. The Council will invite Mr B to provide further evidence and give him more information about how he can access available services.

The complaint

1. Mr B complains about how the Council is meeting his eligible care needs. In summary:

- Mr B considers the Council should increase his care package, in particular, to prepare fresh meals as recommended by his doctor and to support him at night.
- The Council agreed a new disability-related expenditure (DRE) amount in April 2019. However, it has not responded to Mr B's requests to backdate this to August 2018.
- The Council's financial assessment takes into account Mr B's full Attendance Allowance (Attendance Allowance helps with extra costs if you have a disability severe enough that you need someone to help look after you). He considers this should be adjusted to reflect the fact he needs support at night.

The Ombudsman's role and powers

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

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

How I considered this complaint

4. I have considered a complaint form Mr B completed and I have agreed a complaint summary with him. I have invited comments from the Council and

considered its response with supporting evidence including Mr B's care plan and financial assessment.

5. Ms B and the Council had an opportunity to comment on my draft decision. I considered any comments received before making a final decision.

What I found

What should have happened

Charging for care services

6. Councils can make charges for care and support services they provide or arrange. Charges may only cover the cost the council incurs. ***(Care Act 2014, section 14)***

7. Councils must assess a person's finances to decide what contribution he or she should make to a personal budget for care. The scheme must comply with the principles in law and guidance, including that charges should not reduce a person's income below Income Support plus 25%. The Council can take a person's capital and savings into account subject to certain conditions. If a person incurs expenses directly related to any disability he or she has, the Council should take that into account when assessing his or her finances. ***(Care Act 2014 Department for Health, 'Fairer Charging Guidance' 2013, and 'Fairer Contributions Guidance' 2010)***

Disability-related benefits and expenditure

8. The Care Act 2014 and the associated Care and Support Statutory Guidance (the Guidance) Annex C sets out income the Council must consider when deciding what a person should contribute to his or her care.

9. Paragraph 14 says the Council may take most of the benefits people receive into account. However, the Council needs to ensure that in addition to the minimum guaranteed income or personal expenses allowance people retain enough of their benefits to pay for things to meet those needs not being met by it.

10. Paragraph 16 says income from some benefits must be taken into account when considering what a person can afford to pay from their income towards the cost of their care and support in a care home. Attendance Allowance is one of the benefits the Council must take into account when a person is in a care home.

11. Paragraph 39 says that where disability-related benefits are taken into account, the Council should make an assessment and allow the person to keep enough benefit to pay for necessary DRE to meet any needs which are not being met by the Council.

12. Paragraph 40 says when assessing DRE, the Council should include the costs of any specialist items needed to meet the person's disability needs, for example day or night care which is not being arranged by the Council.

24-hour emergency home care response service

13. The Council commissions an emergency response service. This service provides emergency support at home for occasional issues such as assistance with toileting and cleaning up. The service is intended to be for less-frequent call outs. Therefore, if a person uses the service more than 12 times in a four-week period, the Council will discuss whether there is a more appropriate way to meet his or her needs.

What did happen

14. In October 2019, the Council completed a review of Mr B's needs. The assessment commented on Mr B's toileting needs. It recorded Mr B usually only needed to empty his bowels once a day in the morning and carers would support him during the day with this need. The assessment notes *'…Emergency response service offered, this has been declined.'*

15. Mr B complained to the Council the same month. He explained the assessment did not reflect the agreed number of care hours. He wrote again in November 2019 to explain his complaint was about the Council's decision to reduce the number of carers visiting from two to one. He said this effectively halved the care he received.

16. Mr B also said he needed help at night which the Council did not provide. Further, the Council had taken the higher rate of his Attendance Allowance into account when assessing his finances. This meant he was unable to afford the support he needed at night.

17. Mr B has recently told me the Council has increased the care he receives during the day. Therefore, this has resolved the first part of this complaint. However, he remains concerned about the Council's decision on his Attendance Allowance.

18. The Council responded to Mr B's complaint in November 2019. It addressed the issue of reduced care. However, there was no mention of Mr B's Attendance Allowance.

19. Mr B wrote again in December 2019. He said a Council officer told him he could access services 24 hours a day, seven days a week. The Council officer said the Council took his Attendance Allowance into account as it provides these after-hours services. Mr B explained he had contacted a district nurse to visit as he had soiled himself at night. However, the nurse told him it was not her responsibility to visit. Therefore, Mr B had to contact a private care provider for support that night. Mr B also said he would continue to pursue his points of complaint, including *'…my DRE allowance introduction date…'*

20. In January 2020, the Council replied. It said it was usual practice for the full Attendance Allowance to be used when calculating contributions. It also noted Mr B's most recent assessment allowed increased disability-related expenditure (DRE).

21. Mr B complained to the Ombudsman. In response to my enquiries, the Council said it applies the Guidance at Annex C paragraph 16 to financial assessments. This means that it takes the full Attendance Allowance into account.

Analysis

22. The Council says it applies paragraph 16 of Annex C to financial assessments. However, the list of benefits the Council must include under paragraph 16 only applies when the person receiving care is in a care home. This is not the case with Mr B. The Council appears to be applying the Guidance for care in a care home to Mr B's circumstances. This is fault.

23. However, the Guidance at paragraph 14 says that the Council may take most benefits into account in assessing someone's finances. The Guidance lists benefits which must never be included, Attendance Allowance is not on this list. This indicates that the Council has a very broad discretion in deciding which benefits it will include when assessing a person's finances. I therefore do not

consider Mr B has suffered an injustice as a result of the Council including the full amount in his assessment.

24. However, while the Council is entitled to take the Attendance Allowance into account, it must also consider whether Mr B can still pay for any care he receives at night. It should do this by considering whether it should allow any amounts Mr B pays as a DRE as set out in paragraphs 39 and 40 of the Guidance. I cannot see that the Council has considered whether Mr B is entitled to DRE to cover night-time care. This is fault.

25. However, it is not clear, apart from the one instance Mr B has mentioned, whether he has been frequently paying for care at night. For example, for more call outs than would be permitted under the Council's emergency response service. This appears to have caused Mr B uncertainty around whether the Council should be considering any services he pays for as DRE and is a missed opportunity to do so.

26. Mr B has had difficulty accessing the emergency response service. It is not clear whether the district nurse to whom he refers in his complaint forms part of the Council's service or whether he contacted the wrong service in error. I cannot conclude, from the evidence provided, that the Council gave Mr B enough information in this regard. Further, I have seen no evidence the Council tried to clarify how Mr B could access the service following his complaint. Mr B has suffered an injustice as he does not appear to know how to access a service to which he is entitled.

27. I have not seen evidence that Mr B specifically requested the Council consider backdating the increased DRE to August 2018. The reference in Mr B's December 2019 complaint to a 'DRE allowance introduction rate' seems vague. However, the Council has confirmed it has now agreed to backdate the DRE to August 2018.

Agreed action

28. Within one month of my decision, the Council will invite Mr B to provide evidence of any payments for night-time support. It will consider whether any evidence Mr B provides warrants a further increase in his DRE.

29. The Council will again provide Mr B information about its emergency response service and explain how Mr B can access this.

Final decision

30. There is evidence of fault in relation to the financial assessment and how the Council has applied the Guidance. However, the Council may include Mr B's full Attendance Allowance in his financial assessment. The Council will invite Mr B to provide evidence if he pays for night-time support and consider whether it should treat this as DRE. The Council will also ensure Mr B knows how to access the service it provides to meet his night-time toileting needs.

31. I have therefore completed my investigation.

Investigator's final decision on behalf of the Ombudsman

23 November 2020

Complaint reference:
19 017 521

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman will not investigate this complaint that the complainant cannot have unsupervised contact with her grandchildren. This is because there is insufficient evidence of fault by the Council and because an investigation would not lead to a different outcome.

The complaint

1. The complainant, whom I refer to as Mrs X, complains that she cannot have unsupervised contact with her grandchildren. She says it is unfair because she has not done anything wrong.

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 would find fault, or
- it is unlikely further investigation will lead to a different outcome.

(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 considered information about the parents regarding contact. I invited Mrs X to comment on a draft of this decision.

What I found

What happened

4. Mrs X was served with a Child Abduction Warning Notice by the police in 2018. It expired in 2019. Mrs X's partner has been convicted of offences against children.

5. The parents (of Mrs X's grandchildren) have agreed their children cannot have unsupervised contact with Mrs X or her partner. The agreement is indefinite unless the parents ask to change the contact arrangements. The Council would then do assessments. The Council told Mrs X that it does not recommend

unsupervised contact because of the offences committed by Mrs X's partner and because of the events that led to the abduction warning notice. The Council said that decisions about contact rest with the parents but the Council had advised of the possible outcomes regarding unsupervised contact. The Council said Mrs X could get legal advice.

Assessment

6. I will not start an investigation because there is insufficient evidence of fault by the Council and because an investigation would not lead to a different outcome. The Council correctly told Mrs X it is the responsibility of the parents to decide the contact arrangements for their children and it explained the reasons for the supervised contact. I could not change the contact arrangements, even if I started an investigation, because it is for the parents to make decisions about contact. Mrs X, as a grandparent, has no legal right to insist on any form of contact. In addition, due to confidentiality and data protection, there is no more information that could be shared with Mrs X.

Final decision

7. I will not start an investigation because there is insufficient evidence of fault by the Council and because an investigation would not lead to a different outcome.

Investigator's decision on behalf of the Ombudsman

27 November 2020

Complaint reference:
19 013 173

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The complainant, Ms B, said the Council was wrong to decide her mother-in-law, Mrs D, deprived herself of assets to avoid paying care fees. Ms B says the actions of the Council has caused Mrs D and the family avoidable distress and worry. The Council was entitled to pursue the debt, but the Ombudsman found fault in the way the Council decided to pursue Mrs D for the debt. the Council has agreed with the Ombudsman's recommendations and will assess Mrs D's capacity to make specific financial decisions, consider her best interests if necessary and decide who is best placed to manage her finances. The Council will also remind its staff of the importance of completing mental capacity assessments when there is doubt about a person's capacity to make specific decisions.

The complaint

1. The complainant, who I shall refer to as Ms B, complains the Council was wrong to decide her mother-in-law, Mrs D, deprived herself of assets to avoid paying care fees. Ms B and her husband say Mrs D agreed to repay money she owed them when she sold her house in September 2018 and she was not trying to avoid paying for care fees. They say they had never intended for Mrs D to go into care and did not decide she should remain in a nursing home permanently. Ms B believes the Council's decision is wrong and the action taken by the Council to pursue the debt is causing her, her husband and Mrs D avoidable distress and worry. They want the Council to change its view and start to pay their mother's care fees as she does not have enough capital above the lower limit to do so herself.

The Ombudsman's role and powers

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

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

How I considered this complaint

4. I have considered information provided by the complainant and information from the Council in response to my enquiries. I have also considered the law and guidance relevant to this complaint.

5. The complainant and the Council were given an opportunity to respond to a draft of this decision.

What I found

Law and guidance relevant to this complaint

6. The Mental Capacity Act 2005 is the framework for acting and deciding for people who lack the mental capacity to make particular decisions for themselves. The Act (and the Code of Practice 2007) describes the steps a person should take when dealing with someone who may lack capacity to make decisions for themselves. It describes when to assess a person's capacity to make a decision, how to do this, and how to make a decision on behalf of somebody who cannot do so themselves.

7. The council must assess someone's ability to make a decision, when that person's capacity is in doubt. How it assesses capacity may vary depending on the complexity of the decision.

8. A key principle of the Mental Capacity Act 2005 is that any act done for, or any decision made on behalf of a person who lacks capacity must be in that person's best interests.

9. 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 choice available that can achieve the same outcome.

10. The Care Act 2014 is the overarching legislation relating to council's obligations in respect of people who have social care and support needs.

11. The Care and Support statutory guidance (C&SSG) provides councils with the information they need about how they should meet the legal obligations placed on them by the Care Act 2014.

12. Local authorities have a duty to arrange care and support for those with eligible needs, and a power to meet both eligible and non-eligible needs. In all cases, a local authority has the discretion to choose whether to charge under section 14 of the Care Act following a person's needs assessment. Where it decides to charge, it **must** follow the Care and Support (Charging and Assessment of Resources) regulations and have regard to the guidance.

13. Where a local authority has decided to charge, except where a light touch assessment is permissible it **must** carry out a financial assessment of what the person can afford to pay and, once complete, it must give a written record of that assessment to the person.

14. At the time of the assessment of care and support needs, the local authority must establish whether the person has the capacity to take part in the assessment. If the person lacks capacity, the local authority must find out if the person has any of the following as the appropriate person will need to be involved:

- enduring power of attorney (EPA)

- lasting power of attorney (LPA) for property and affairs
- lasting power of attorney (LPA) for health and welfare
- property and affairs deputyship under the Court of Protection
- any other person dealing with that person's affairs (for example, someone who has been given appointeeship by the Department for Work and Pensions (DWP) for the purpose of benefits payments)

15. The financial limit, known as the 'upper capital limit', exists for the purposes of the financial assessment. This sets out at what point a person is entitled to access local authority support to meet their eligible needs.

16. The upper capital limit is currently set at £23,250. Below this level, a person can seek means-tested support from the local authority. This means that the local authority will undertake a financial assessment of the person's assets and will make a charge based on what the person can afford to pay. In the financial assessment capital below the lower capital limit – currently set at £14,250 – is not considered in the assessment of what a person can pay in tariff income assessed against their capital. Where a person's resources are below the lower capital limit of £14,250, they will not need to contribute to the cost of their care and support from their capital.

17. Where a person has accrued a debt, the local authority may use its powers under the Care Act to recover that debt. In deciding how to proceed, the local authority should consider the circumstances of the case before deciding a course of action. For example, a local authority should consider whether this was a deliberate avoidance of payment or due to circumstances beyond the person's control.

What happened

18. Mrs D lived on her own in a property she owned but was diagnosed with dementia in 2014. She received informal support from her son and daughter-in-law, Ms B. They said Mrs D relied on them to complete grocery shopping which they paid for due to her limited income.

19. In 2016 the Council had contact with Mrs D about her social care needs. The Council said Mrs D did not need any social care support at the time.

20. In mid-2018 Mrs D decided to sell her home and her family helped her to apply to the district council for housing accommodation. Mrs D had experienced falls at home so needed level access accommodation. The Council's records show details of Ms B's request for an occupational therapy assessment as Mrs D struggled with stairs. After the sale of the property completed Mrs D moved to her son's and Ms B's home. Ms B provided her with informal care and support while she waited for the district council to provide accommodation. A short while later Ms B had an operation and said she was unable to continue caring for Mrs D. She contacted the Council for advice and assistance.

21. Ms B contacted the Council due to the difficulties she was having, and it provided advice and information about respite care. Mrs D went into a residential care home for respite in December 2018 which was arranged by her family. At this time Mrs D had enough capital above the capital limit to self-fund the residential placement.

22. The care home contacted the Council in February 2019 about Mrs D's finances. The care home asked for a financial assessment and said they were concerned as Mrs D did not have a social worker but needed a review of her care needs.

The Council's notes states "*daughter and son are dealing with finances but thought the threshold was £13,000 and are now below the threshold of £23,250*".

23. The Council's officer visited Mrs D in the care home and completed a care and support assessment. The Council said Ms B was present at the assessment as well as a representative from the home. The assessment recorded that Mrs D could not manage her finances independently and had support from her son to do so. However, no legal documents were in place such as an enduring or lasting power of attorney. The assessment noted that Mrs D had an Appointee for her state benefits but did not record the details of the person.

24. The Council started to fund Mrs D's care fees from April, and it said Ms B completed a financial assessment form in May. After this it considered deprivation of assets. In May, its Financial Assessment Officer (FAO) went to visit Mrs D in the care home to complete a financial assessment.

25. A council officer completed a mental capacity decision to assess whether Mrs D had capacity to agree to the placement. The assessor concluded Mrs D had capacity to make this specific decision. Following a review of Mrs D's care needs the placement became permanent.

26. The Council wrote to Mrs D at the care home after the financial assessment. In summary it said:

- it had calculated Mrs D's savings fell below the maximum capital threshold of £23,250 in April 2019;
- she had been assessed to pay the full cost of her care which at the time was £588 weekly;
- the FAO had told her at the time of the visit in the care home an amount of £30,000 she had gifted to her son and Ms B would be included as if she still had these savings herself to pay for her care needs; and
- the Council would now be paying the care home on Mrs D's behalf.

27. Mrs D's son was unhappy with the decision made by the Council and so complained. The Council replied to the complaint and specifically about the £30,000 gift it said it was entitled to recover the lost income from charges in line with the Care Act 2014. So, it could assess how much she could afford to pay as if she still possessed the asset and recover 'lost income' from Mrs D. The complainant then asked the Ombudsman to consider the complaint.

Findings

28. The information provided by the Council suggests Mrs D was diagnosed with dementia as early as 2014. Although the Council did not provide her with formal support it had information to suggest Mrs D had difficulty managing her finances a few years before she needed formal support.

29. There is no dispute about whether Mrs D needed respite at the time she went into the residential care home. Ms B and her husband say they did not decide for the placement to be permanent as Mrs D was waiting for council accommodation to be provided. On the evidence available, it is likely Mrs D herself decided to stay in the placement.

30. The Council completed capacity assessments to ensure Mrs D could make the decision. The assessment of her needs showed she needed care and support for at least 12 hours daily. If her needs were to be met in the community it is likely Mrs D would need regular informal care and/or a substantial formal home care

package in place. The Council's assessor also recorded sheltered housing would have been unsuitable to meet Mrs D's care needs. I do not find fault in the way the Council supported Mrs D's decision to make the placement permanent.

31. Ms B and her husband say Mrs D repaid them £30,000 after she sold her house for debts she had accrued when they paid for her groceries and paid some bills over several years. The Council has asked them to provide receipts so it can consider reviewing its decision. Ms B said the payments were made in cash which explains why it may be difficult to provide receipts.

32. The C&SSG says, "*when undertaking or reviewing a financial assessment a local authority may identify circumstances that suggest that a person may have deliberately deprived themselves of assets in order to reduce the level of the contribution towards the cost of their care… But deprivation should not be automatically assumed, there may be valid reasons why someone no longer has an asset and a local authority should ensure it fully explore this first*."

33. On the evidence available, it is likely the Council has done some exploration to find out why Mrs D no longer has the asset. For example, it has spoken to Mrs D's son and Ms B and asked them to provide receipts to show how the debt accrued. I do not find fault in relation to this action.

34. The information in the Council's files confirms Mrs D was not managing her finances independently before she moved to the care home. The assessment completed by the Council after Mrs D had moved to the care home confirmed she could not manage her finances independently and received support to do so. It is unclear whether Mrs D completed the transaction to transfer the funds in dispute or someone did this on her behalf.

35. The information in the Council's files suggest there is doubt about Mrs D's capacity to make financial decisions. In addition, it was already aware she had an impairment or disturbance in the functioning of her mind because she had dementia. Despite this the Council's FAO went to discuss finances in the care home with Mrs D. Following this visit the Council's finance department wrote to Mrs D about the debt. The Council should have taken reasonable steps to establish Mrs D's capacity to make specific financial decisions. For example, it should have completed a formal mental capacity assessment. The Council did not do this and is at fault.

36. The Council was also aware that Mrs D did not have a Deputy to deal with her property and financial affairs. It recorded she had an Appointee for benefits but did not record the name of that person in the assessment. This is fault. If the Council had completed a capacity assessment to decide whether Mrs D could manage her finances, it could have then considered her best interests if the capacity assessment determined she lacked capacity. Although the Council refers to best interests in its case records it has not followed a formal process. I find the Council at fault.

37. In addition, the C&SSG says, "*where the person has transferred the asset to a third party to avoid the charge, the third party is liable to pay the local authority the difference between what it would have charged and did charge the person receiving care. However, the third party is not liable to pay anything which exceeds the benefit they have received from the transfer."* In Mrs D's case the funds have been transferred to a third party. Therefore, I find fault in the way the Council decided to pursue Mrs D for the debt.

38. The Council said it did not consider pursuing the recipient of the gifted funds in line with the Care Act 2014. It said it reached this decision on the basis that Ms B was experiencing stress and anxiety due to the financial situation and because of her health issues. The Council was entitled to make this decision.

39. When the Council wrote to Mrs D said it would pay the care home on her behalf. In response to the Ombudsman's enquiries the Council confirmed it has funded the placement from April 2019. Ms B and her husband want the Council to pay Mrs D's care fees as an outcome to this complaint, but it appears the Council is already doing so. Therefore, it is not necessary for the Ombudsman to consider making a recommendation about this specific point. The debt in dispute relates to how much the Council assessed Mrs D needed to contribute to her care costs.

Conclusion

40. The Ombudsman cannot decide whether deprivation of assets has occurred in this or any case. It is up to councils to decide whether someone (or a third party) has deliberately deprived themselves of assets to avoid paying care fees. The Council was entitled to consider the £30,000 gift when it assessed Mrs D's finances. The C&SSG says, it is important for people to pay the contribution to their care costs they are responsible for. This is important to the overall affordability of the care and support system.

41. The Care Act 2014 gives councils powers to recover a debt which has accrued because of deprivation of assets. The C&SSG says councils should "*consider the circumstances of the case before deciding a course of action. For example, a local authority should consider whether this was a deliberate avoidance of payment or due to circumstances beyond the person's control*". It is up to the person to prove to the Council that they no longer have the asset.

42. The Ombudsman is concerned about Mrs D's ability to understand the financial implications of this debt situation. There is doubt about her capacity to make and understand financial decisions. It is unclear whether she has suitable support in place to help her manage her finances.

43. There is fault in the way the Council decided to pursue Mrs D for the debt. This causes a potential injustice if Mrs D is found to lack capacity to make specific financial decisions. The Council should act to assess her capacity and consider her best interests if necessary. The Council should properly consider the circumstances of this case before it continues to pursue the debt. Once it has done so it may then decide the best course of action, for example, continuing with its decision to pursue the debt.

Agreed action

44. The Council has agreed to the Ombudsman's recommendations and within four weeks of the date of the final decision it will:

- assess Mrs D's capacity to understand and make specific financial decisions;
- considers Mrs D's best interests if the assessment determines she lacks capacity;
- decides who is best placed to manage Mrs D's finances if she cannot do so herself and if there is no other suitable person to act on her behalf;
- considers whether any injustice has been caused to Mrs D pending the outcome of the capacity assessment;

- writes to Ms B and her husband to confirm what action it will take regarding the debt once it has properly considered the full circumstances of this case;
- remind its staff of the importance of completing capacity assessments when there is doubt about a person's capacity to make specific decision. This should be reiterated to its social work and financial assessment team in particular; and
- provide an update to the Ombudsman to show the outcome of the assessment, any actions taken in Mrs D's best interests if appropriate, what it has done to put things right if there has been injustice and confirm its further decisions about the debt.

Final decision

45. I have completed my investigation and uphold Ms B's complaint. The Council was entitled to pursue the debt but there is fault in the way the Council decided to pursue the debt, and this caused injustice to Mrs D. I am satisfied the action the Council will take to complete the agreed recommendations will remedy the injustice caused.

Investigator's decision on behalf of the Ombudsman