9 February 2017

Complaint reference:
16 006 916

Complaint against:
Nottinghamshire County Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: The Council failed to secure the best possible price for land it disposed of. It also failed to give the finance and property committee all the information it needed to make an informed decision. But I cannot conclude that had these faults not occurred Mr B would have been the successful bidder. It has, however, caused him some uncertainty.

The complaint

1. Mr B complains that the Council failed to follow the correct process when selling agricultural land it owned (land A). He argues that the Council already had a preferred bidder and failed to give his bid proper consideration.
2. Mr B also argues that the Council failed to ensure that the tenant of land A was paying the market rate in rent.

What I have investigated

3. I have only investigated the first part of Mr B's complaint.
4. The final section of my report explains my reasons for not investigating the rest of the complaint.

The Ombudsman's role and powers

5. The Ombudsman investigates complaints of injustice caused by maladministration and service failure. I have used the word fault to refer to these. The Ombudsman cannot question whether a council's decision is right or wrong simply because the complainant disagrees with it. She must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, section 34(3))***

How I considered this complaint

6. I have:

- Read the papers submitted by Mr B and discussed the complaint with him.
- Considered the Council's comments about the complaint and the supporting documents it provided.
- Made a third party enquiry to the Council's auditors.
- Shared my draft decision with Mr B, the Council and the third party and considered their responses.

What I found

Law and guidance

Local Government Act 1972

7. Local authorities are given powers under the 1972 Act to dispose of land in any manner they wish, including sale of their freehold interest, granting a lease or assigning any unexpired term on a lease, and the granting of easements. The only constraint is the disposal must be for the best consideration reasonably obtainable, unless the secretary of state consents to the disposal.

8. It is government policy that local authorities and other public bodies should dispose of surplus land wherever possible. It is expected that land should be sold for the best consideration reasonably obtainable. However, it is recognised that there may be circumstances where an authority considers it appropriate to dispose of land at an undervalue.

Council's constitution

9. The Council's constitution sets out the process for disposing of land by informal tender. It states that the "*Service Director, Transport, Property and Environment, in consultation with the chairman of the Finance and Property Committee will make arrangements in appropriate cases for properties to be sold by open informal tender which must be preceded by public advert subject to appropriate limits*".

Events leading to the complaint

Council puts land up for sale

10. On 12 October 2015 the finance and property committee decided the Council should sell land A and use an estate agent to manage the process and advertise the sale

11. The estate agent's brochure about the sale said "*the land will be sold subject to a development uplift clause. The uplift clause specifies that 25% of any increase in value of the land due to development (as defined in section 55 of the Town and Country Planning Act 1990) will be payable to the vendors or their successors in title such development occur within 50 years from the date of completion*".

12. The Council advertised the sale on the estate agents website, a third party property website and a farming website.

13. The Council received two offers for land A, one from Mr B and the other from bidder 2, who was the previous tenant of land A. The estate agent then wrote to both bidders and asked for best and final offers by 12 noon on 18 December 2015. Mr B argues that the Council should have split the land into different lots to attract more bidders. He argues that not doing so favoured bidder 2 who had previously been linked to the Council in a professional capacity. Mr B believes that this has meant that the Council failed to secure the best possible price for the land.

14. On 18 December 2015 Mr B put in another offer which increased the overage to 35% but kept the cash amount the same (offer X). Bidder 2 placed an escalating bid, to increase any other offers received by £1000 up to a maximum of Y with a 25% overage rate. An overage clause gives the seller of a property the right to share in any increase in value that might occur because of planning permission being granted at a later date.

15. Mr B then sent a late offer to the Council on 18 January 2016. He increased his cash offer to X+1 and kept the increased 35% overage. He also said some of the land would be available for the community to use.

16. The Council decided not to put this offer before the property and finance committee because it was late. This is relevant because the Parish Council, on 10 November 2015, raised its concerns with the Council that it was selling land A without any allocation for community allotments. It also raised concerns about the low overage rate because of the likelihood of land A being developed in the future as identified in the local plan.

17. The property and finance committee considered Mr B's second offer (X) alongside the escalating offer from bidder 2 on 25 January. The Council's report to the committee provided the details of both offers. It said that Bidder 2 had the highest offer out of the two bids. When considering overage and development potential the report said "*it it thought that there may be limited future development potential...This would however be subject to policy change by the local planning authority*". The committee decided to approve bidder 2 to buy land A because it considered that bidder 2 had the highest offer.

18. The Council completed the sale with bidder 2 in March 2016.

Mr B complains to the Council

19. Mr B wrote to the Council about the sale of land A in February 2016. He said the Council had not followed the correct process and had failed in its statutory duty to secure the best price for the land. Mr B said the Council had failed to:

- Give his overage rate proper consideration because some of land A featured in the Council's local plan for possible development.
- Advertise land A in line with legislation.
- Review rental rates in line with market rates.
- Give the current tenant timely notice so any buyer could not take the land until Autumn 2017. This would be a disadvantage for anyone wishing to buy the land except the existing tenant.

20. In response to Mr B's concerns, the Council said it only reported bids it received within the deadline to the property and finance committee. The committee then approved the sale to the highest offer, bidder 2. But even if it had accepted Mr B's late offer (X+1) it was still lower, in monetary terms, than bidder 2's offer. It said that planning permission does not exist for the land and therefore there was no uplift or overage to quantify.

21. The Council said it openly marketed land A in the national press and many property portals and the Council was in no doubt that it marketed the land openly and fairly. It also explained that the committee took the decision to sell the land after the tenancy renewal date. It said there would have been no advantage in the Council serving notice between the committee date and the anticipated sale date. This is because the buyer of the land can still serve notice with the same effective 2017 date.

22. Mr B remained concerned about the Council's consideration of his offer, especially the overage rate. He provided the Council with details of case law which supported the view that the Council should have taken overage into account when it disposed of land A. Mr B asked for the Council to review the sale before it completed the sale.

23. In response to Mr B's concerns and complaints the Council again said that it was satisfied that it had followed the correct process when selling the land. It explained that the committee considered his increased overage offer but decided that bidder 2's offer was of a higher value than his. The Council also said that it would be wrong to accept late offers and the Council ethically took the correct approach.

24. I have seen evidence that following Mr B's complaints the Council also completed a report to consider the potential future income from overage claw back if development did take place on land A. This report explained that the neighbourhood local plan was still in development but the Council had identified part of land A for potential development. It said if the development went ahead as planned a 35% overage rate, instead of 25%, could result in the Council receiving another £8769. But it reminded readers that no planning consent exists for land A because the Council was still developing the neighbourhood plan.

25. This report was written after the finance and property committee made its decision in January 2016. Therefore the committee did not have access to any detailed analysis about potential development opportunity or overage estimates. The Council also failed to tell the committee that some of Land A had been identified for development in the draft local plan.

26. Mr B filed a number of freedom of information requests about the sale of land A. In response, the Council provided Mr B with details of bidder 2's escalating bid and more details of its overage consideration. It explained that "*because there was no development scheme in place or known timeframe for its delivery the uplift is unquantifiable. Bearing this in mind, a decision to recommend the best value bid was taken*".

27. Mr B sent a formal complaint to the Council in June 2016 after receiving all the information he sought from his freedom of information requests. He remained dissatisfied with the Council's responses to his queries and said the Council had failed to secure the best consideration for land A. The Council did not uphold Mr B's complaint and directed him to the Ombudsman.

Analysis

28. When the Council decided to put land A up for sale it did so through its proper process using the finance and property committee. The committee met, and decided it should sell land A, after the tenancy renewal date. So although the terms of sale may not have been convenient for Mr B, he was aware of them at the time he placed his offer. Therefore, I have found no fault with the Council about the timing of its decision to serve notice on land A's tenant. The Council also followed its constitution when it advertised the land.

29. Although there were no formal restrictions about escalating bids, accepting such an offer has resulted in the Council failing to secure the best possible price. Bidder 2 said they were willing to raise any offer by £1000 up to the value of Y. Therefore bidder 2 was willing to pay Y for the land. When the Council asked for best and final offers it should have gone back to bidder 2 and asked what their final offer was. If the Council had done this I consider that it would have been more likely than not that bidder 2 would have given Y as their best and final offer.

30. Mr B submitted his second offer of X+1 after the deadline but before the finance and property committee, the decision makers, met. It is the Council's statutory duty to ensure that it secures the best possible price for the land. Therefore the Council should have put the late offer in front of the committee, explaining that it

was late. The committee would then have had the opportunity to weigh up whether to accept the late bid, taking its statutory responsibilities into account. The committee should have also had access to the Parish Council's comments about the sale. Had the Council done this, I consider that it is more likely than not that the committee would have accepted Mr B's late bid. But this does not mean that Mr B would have been successful because his bid of X+1 was still lower, in financial terms, than bidder 2's Y offer. It does, however, mean that the Council would have secured significantly higher amount for the sale of the land.

31. The Council gave the property and finance committee details of overage offers from both parties. But the report to the committee only contained limited details of potential development for the land. After Mr B's complained to the Council it completed a more detailed report about overage which weighed up the potential financial gain of accepting a higher overage offer. But it should have ensured this report was completed before the committee met to enable it to reach an informed decision, not after Mr B complained to the Council.

32. Mr B complains that the overage report underestimates the value of the land and contained factually incorrect information. But the Council failed to put this report before the committee therefore it was not taken into account. But in any event, if it had been put before the committee, the committee would have been the appropriate body to scrutinise the content of this report.

33. Therefore the Council was at fault for failing to properly consider Mr B's increased overage offer and failed to secure the best possible price for land A. But I cannot conclude that had the committee considered this information it would have approved Mr B's offer instead of bidder 2's. This is because it relates to an unconfirmed financial value. I do not know how much weight the committee would have given to the differing overage rates had it had all the relevant information. It has, however, caused him some uncertainty about whether he would have secured land A and time and trouble in pursing his complaint.

34. Mr B states that the Council failed to follow the correct process because of bidder 2's previous professional involvement with the Council. I have not seen any evidence to support this view. But, because of this, the Council should have taken special attention to ensure that it followed the correct process. Failure to do so has caused Mr B some additional uncertainty about the Council's impartiality when it made its decision.

Agreed action

35. In recognition of the faults identified above the Council, within six weeks of my final decision, has agreed to:

- Apologise to Mr B to the uncertainty and time and trouble he has experienced.
- Pay Mr B £500 to recognise this uncertainty and time and trouble he has experienced.

Final decision

36. The Council failed to secure the best possible price for land it disposed of. It also failed to give the finance and property committee all the information it needed to make an informed decision. But I cannot conclude that had these faults not occurred Mr B would have been the successful bidder. It has, however, caused

him some uncertainty. The Council has agreed to my recommendations and therefore I have completed my investigation.

Parts of the complaint that I did not investigate

37. I have not investigated Mr B's complaint about rental rates because there is no evidence to suggest that this caused him any injustice.

Investigator's decision on behalf of the Ombudsman

30 November 2016

Complaint reference:
15 020 232

Complaint against:
Nottinghamshire County Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: There was fault in the way the Council carried out safeguarding investigations relating to the complainant and his late sister. The Council has agreed to take action to remedy the complainant's injustice.

The complaint

1. Mr B complains about the Council's safeguarding investigations into the care provided to his late sister. He also complains about a safeguarding investigation which related to his actions.

The Ombudsman's role and powers

2. The Ombudsman investigates complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. If there has been fault, the Ombudsman considers whether it has caused an injustice and if it has, she may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1))***

3. Where we find fault which has caused distress, harm, risk, or another unfair impact to a person who has died, we will not normally seek a substantive remedy in the same way as we might for someone who is still living. We would not expect a public or private body to make a payment that would enrich a person's estate.

4. The Ombudsman cannot question whether a council's decision is right or wrong simply because the complainant disagrees with it. She must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, section 34(3))***

How I considered this complaint

5. I have:

- considered the complaint and the documents provided by the complainant;
- discussed the issues with the complainant;
- made enquiries of the Council and considered the comments and documents the Council has provided; and
- given the Council and the complainant the opportunity to comment on my draft decision.

What I found

6. Mr B's sister, S, moved into a residential care home in February 2014. An incident at the care home in May 2014 resulted in two safeguarding complaints. Mr B complained that the way a carer transferred S caused her pain and distress. A witness to the same incident complained that Mr B had shouted at the carer which had distressed another service user.

7. The Council investigated the two safeguarding referrals separately. Initially it told Mr B that he could not visit S at the care home while it was investigating the complaint against him. However, after Mr B objected, it agreed that he could continue to visit S at the care home, but only between 6pm and 8pm in the evening. The Council told Mr B that it would not allow the carer to work directly with S while it was carrying out its investigations.

8. After carrying out some interviews, the Council told Mr B that it would not be pursuing the safeguarding complaint that had been made about him.

9. As part of the Council's investigation into the carer's actions, a social worker interviewed Mr B and other witnesses. The Council decided that it was not possible to determine whether the alleged abuse took place or not and it recorded the outcome as inconclusive.

10. Two social workers visited Mr B to explain the outcome. They told Mr B that they had recommended that the carer start working with S again. Mr B was not happy with this and said he would call the police if he saw the carer working with S. Mr B asked the social workers to note that no-one had told him that the visiting restrictions had been lifted when the Council decided not to pursue the complaint about him.

11. Mr B says that during the visit, he asked if he could appeal the Council's decision on the complaint he had made. He says that the Social Worker told him that she would look into whether he could appeal and would let him know. Mr B says that she did not get back to him.

12. Following contact from both the Council and Mr B, the care home manager agreed that the carer would not work directly with S again.

13. In June 2014, the Council told Mr B that it had received another safeguarding referral involving a different carer and S. It told Mr B that it had suspended the carer.

14. S moved to another care home in October 2014.

15. In around March 2015, following further contact about the safeguarding complaint made by Mr B, the Council wrote to Mr B confirming the outcome of its investigation.

16. Mr B then made a formal complaint to the Council. He complained that it had not told him the outcome of the last safeguarding investigation and he did not know if the carer had been able to return to her position and work with S.

17. Mr B also complained that the Council had not dealt with his request to appeal its decision on the safeguarding complaint he made. He said that it had not given him any information about the safeguarding process.

18. In the Council's response it said that it had completed the last safeguarding investigation and had recommended formal disciplinary procedures for the member of staff. It explained that employment investigations are strictly

confidential and it could not share the outcome of this with him. It apologised that it had not told Mr B about the outcome of this safeguarding investigation.

19. The Council thanked Mr B for raising his concerns and said that it now writes to all referrers advising of the outcome following face to face feedback. The Council did not respond to Mr B's concerns about the lack of information about the process or his request to appeal the decision.

20. Mr B was not satisfied with the Council's response and escalated his complaint. Two managers from social care and a complaints officer then met with Mr B in September 2015.

21. Mr B said that he did not agree with the outcome of the investigation into the safeguarding complaint he made. He said that he had witnessed the abuse and considered the investigation was inadequate. He explained his view that the Council should have stopped the carer from working in communal areas used by S.

22. The Team Manager said that the Council had followed the proper safeguarding procedures and had reached its decision on the balance of probabilities. However, the Group Manager acknowledged that the investigation should have recommended that the alleged perpetrator not work in the same bungalow as S again.

23. Mr B said that he considered the Council failed to support S or him through the process. He said that the Council should have given him a leaflet explaining the safeguarding process and where he could go if he disagreed with the outcome.

24. The Council wrote to Mr B following the meeting. It confirmed that he could not appeal the safeguarding decision but he could complain about the process to the Council's Safeguarding Board. It acknowledged that staff working on the safeguarding investigations should have given him information about this at the time and agreed that as an organisation it should provide written information to families. It agreed to look into what improvements it could make.

25. It told Mr B that two people were suspended and put through disciplinary procedures in relation to the last safeguarding referral.

26. S passed away in January 2016.

The law and government guidance

27. A council must make necessary enquiries if it has reason to think a person may be experiencing, or at risk of abuse or neglect and has needs for care and support which mean he or she cannot protect himself or herself. It must also decide whether it or another person or agency should take any action to protect the person from abuse.

28. The 'No Secrets' guidance published by the Department of Health states:

"Information leaflets should be produced in different, user friendly formats for service users and their carers. These should explain clearly what abuse is and also how to express concern and make a complaint. Service users and carers should be informed that their concern or complaint will be taken seriously, be dealt with independently and that they will be kept informed of the outcome. They should be reassured that they will receive help and support in taking action on their own behalf."

"Whenever a complaint or allegation of abuse is made all agencies should keep clear and accurate records and each agency should identify procedures for

incorporating, on receipt of a complaint or allegation, all relevant agency and service user records into a file to record all action taken."

"In deciding what action to take, the rights of all people to make choices and take risks and their capacity to make decisions about arrangements for investigating or managing the abusive situation should be taken into account."

Analysis

29. Mr B says that the Council failed to properly investigate the complaint he made about abuse that he witnessed. He considers the Council should have interviewed S. The Council says that it did not interview S in relation to the allegations of abuse because it considered she lacked capacity. The Investigating Officer's report states that Mr B told her that S would not have the capacity to engage in an interview and would be unable to remember the incident or provide information about it. The report also states that professionals who were supporting S also said that she would be unable to engage in an interview. They said that S would be unable to recall the incident which may then in turn cause her increased confusion and distress. I have found no evidence of fault in the way the Council reached the decision to not interview S as part of its investigations.

30. The Investigating Officer's report states that the alleged perpetrator should not work with S while she remains at the care home. However, the same officer told Mr B during the face-to-face meeting that she had recommended that the carer re-start supporting S. I do not consider the Council's records are clear here. This is fault.

31. Mr B considers the Council was wrong to recommend that the carer work with S again following the safeguarding investigation. The care home manager agreed that the carer would not work directly with S. However, she still worked in the same bungalow and so could come into contact with S in communal areas. The Council has since accepted that the safeguarding investigation should have recommended that the carer not work in the same bungalow as S again. I consider this failing caused Mr B unnecessary distress.

32. I am satisfied that the Council properly investigated Mr B's safeguarding complaint. It interviewed Mr B and staff members. I appreciate that Mr B strongly feels the Council's 'inconclusive' decision is wrong, but I have found no evidence of fault in the way it was reached.

33. When it concluded the investigation, the Council failed to write to Mr B with details of the outcome and its recommendations. This was fault.

34. When Mr B asked to appeal the Council's decision, it failed to tell Mr B that there is no right of appeal but that he could complain about the process to the Adults Safeguarding Board. This was fault and caused Mr B to feel that the Council was not being open and transparent.

35. Mr B knew that a safeguarding complaint had also been made about him and that it related to the same incident. The Council told Mr B that it was not pursuing the investigation but it did not confirm this to Mr B in writing. This was fault.

36. The Council did not explain to Mr B why it had restricted the times he could visit S. The Investigating Officer decided that the restriction should be lifted when she decided not to pursue the safeguarding investigation. However, the Council failed to tell Mr B. This was fault and caused Mr B some distress.

37. Mr B would like the Council to destroy its records relating to the allegation about him. The Council did not conclude that the allegations were false. I therefore do

not consider there are grounds to ask the Council to remove details of the investigation from its records.

38. The Council records show that it decided to terminate the safeguarding assessment but do not explain the reason for this decision. This is fault.

39. When the Council told Mr B that it had received a safeguarding referral involving a different carer and S, it said that it could not share any details with him, other than that S was ok and it had suspended the staff member.

40. The Council did not give Mr B any updates about the investigation. He did not know the outcome of the investigation or whether the carer had returned to work with S. The Council should have kept Mr B updated and told him the outcome of its investigation. This was fault and caused Mr B unnecessary distress.

41. The Council did not complete its safeguarding investigation. Instead, it decided to investigate the alleged abuse through its disciplinary procedures. This was fault. I do not consider this failing affected Mr B because the alleged perpetrator remained suspended until after S left the care home.

42. In response to Mr B's complaint, the Council told him that two carers were suspended and put through disciplinary procedures. This is not the case; the Council suspended one carer and put her through disciplinary procedures. The Council should not have given Mr B incorrect information. This was fault and again caused Mr B to feel that the Council was not being open and transparent.

43. Mr B would like further information about what happened to S and led to the investigation. The Council is not obliged to provide this information. I have found no evidence of fault here.

44. Mr B considers the Council should have told S's new care home about the safeguarding investigations so that it could support her appropriately. The Council says that it did not share this information with the new care home because it did not consider it needed to know about it. I have found no evidence of fault here.

45. Mr B considers the Council failed to support S or him through the safeguarding process. The Council accepts that it should have given Mr B a leaflet explaining the safeguarding process. It did not provide any written information to Mr B about the process or where he could get support if he felt he needed it. This was fault.

46. In the Council's response to my enquiries, it said that Mr B was advocating for S. It said that once it was identified that there was conflict, it was recommended that S be referred for an independent advocate, which is usual practice.

47. The Council's policy says:

"Where an adult at risk has substantial difficulty in being involved in the process and there is no other suitable person to represent and support them, the local authority must arrange for an independent advocate to represent and support them."

48. The Council should have arranged for an advocate to support S while it was carrying out the safeguarding investigation. It did not do so until 14 August 2014, when it had completed the investigation. This was fault.

Agreed action

49. The Council has agreed to apologise to Mr B for the failings identified in this case. It has also agreed to review its procedures and take any other necessary steps to ensure its staff:

- provide a leaflet to individuals involved in a safeguarding complaint which contains information about the process;
- inform service users and referrers of the outcome, in writing;
- provide support to service users if necessary;
- provide support to referrers or details of where they can get support if they feel they need it;
- keep clear and accurate records detailing all actions taken and when, and the reasons for its decisions; and
- quickly identify whether an advocate is necessary.

Final decision

50. I have completed my investigation and uphold Mr B's complaint. There was fault by the Council which caused injustice to Mr B. The actions the Council has agreed to take are sufficient to remedy his injustice.

Investigator's decision on behalf of the Ombudsman

01 November 2016

Complaint reference:
15 019 148

Complaint against:
Nottinghamshire County Council

Location of care:
Rose Court Care Home

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: The care provider, acting on behalf of the Council, failed to act promptly when Mrs H was in pain, and failed to keep proper records. It was not able to give Mrs B a proper explanation of the way her mother suffered a serious injury. The Council was already monitoring the care home. It completed the safeguarding investigation in accordance with its procedures. However, as the funding authority it remained responsible for Mrs H's care while she was in the care home and agrees to offer a payment to Mrs B in acknowledgement of the distress caused by some poor standards of care.

The complaint

1. The complainant (whom I shall call Mrs B) complains that the care provider Embrace, acting on behalf of the Council, was unable to explain how her elderly mother Mrs H suffered a serious injury while in its care in the residential home Rose Court. She says the Council was unwilling to move Mrs H to another home when Mrs B asked.

The Ombudsman's role and powers

2. The Ombudsman investigates complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. She 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, she may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1))***

How I considered this complaint

3. I considered all the written information provided by the Council and Mrs B. I spoke to Mrs B. Both Mrs B and the Council had the opportunity to comment on an earlier draft of this statement before I reached a final decision.

What I found

Relevant legal background

4. The Ombudsman has powers to investigate adult social care complaints in both Part 3 and Part 3A of the Local Government Act 1974. Part 3 covers complaints

where local councils provide services themselves, or arrange or commission care services from social care providers, even if the council charges the person receiving care for the services. The Ombudsman can by law treat the actions of the care provider as if they were the actions of the council in those cases. ***(Part 3 and Part 3A Local Government Act 1974; section 25(6) & (7) of the Act)***

5. A council must make necessary enquiries if it has reason to think a person may be at risk of abuse or neglect and has needs for care and support which mean he or she cannot protect himself or herself. It must also decide whether it or another person or agency should take any action to protect the person from abuse or risk. ***(section 42, Care Act 2014)***

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

7. The CQC issues guidance to care providers on compliance with the fundamental standards of care (known as the *Essential Standards* at the time of these events). *Essential Standards* says that care providers should comply with the regulations by ensuring that records about care treatment and support are clear, factual and accurate. Records should be updated as soon as practicable and kept safe.

8. *Essential Standards* also says that staff should quickly recognise when service users becomes seriously ill and requires treatment, and immediately respond to meet those needs.

What happened

9. Mrs H, an elderly lady who suffered with dementia, moved into long term care in Rose Court in December 2013. The Council partly funded her care. Mrs B, her daughter who was her main carer before Mrs H moved into the care home, says she started to have concerns about the standard of care in the care home in early 2014.

10. The Council's records show Mrs B contacted the Council in March 2014 and asked if Mrs H could move homes, as she thought her mother needed a nursing home rather than a residential care home. She said her mother's general condition and mobility had deteriorated. After an assessment by a district nurse, the Council told Mrs B that her mother did not need nursing care. However, the social worker told Mrs B she would arrange a review to address her concerns.

11. Mrs B contacted the social worker again in April on the advice of the CQC as she had continuing concerns about the standards of care in the home, and said the home would not call a GP to Mrs H until she insisted, even though Mrs B had found bumps on Mrs H's head. She said Mrs H had fallen in the home but this had not been recorded. She said she had arrived at the home to find her mother in a stupor, with her core temperature very low. The social worker explained how to raise a safeguarding alert. She also arranged a review of Mrs H's care. The Council's records for 1 May record, "*Safeguarding allegation to be investigated by (safeguarding officer).On-going concerns with the home since management changes - poor practice/poor care planning/poor nursing oversight/practice*".

12. The safeguarding strategy discussion record notes that "*Given the evidence of injuries and the on-going poor practice regarding this resident's care, it was agreed that SAIO* [the safeguarding officer] *would visit Nursing Home this week*

and undertake an investigation looking at care planning, daily logs, medical/medication charts and active planning for emerging care needs".

13. The notes of the review of Mrs H's care on 13 May record that an action plan was drawn up by the home manager in view of Mrs B's concerns. The notes also record, *"(Mrs B) stated she was happy with the meeting and is prepared to see if (Mrs H's) care improves before making a decision to possibly move her."* The social worker recorded a further call to Mrs B in July, when she recorded that care had improved and Mrs B said she was happy for Mrs H to remain in the home now that the long-term manager had returned.

14. Mrs B says in August she visited her mother to find that staff did not know where she was. Mrs B says her mother was later found in her room half naked. Mrs B says she made an informal complaint to the home at the time as she says Mrs H would never have been able to get herself into that position.

Mrs H's hospital admission

15. On 29 August the ambulance service was called out to Mrs H at the home. The ambulance service made a safeguarding referral to the Council. It said, "*Patient lives in residential home. She complained of chest pain to staff yesterday evening, they gave her indigestion remedy and then was fine all evening. The evening staff did not pass the info to the morning staff and the patient was crying in pain when the morning staff arrived….. On crew's assessments, she was still crying in pain, the crew then did an observation on her chest and found a very large bruise on her chest/sternum and also felt like some crepitus (broken bone feeling). The patient is fully immobile and will not attempt to get out of bed in general. The crew stated that even if she were to fall out of the bed it would be impossible to get an injury like that. The injury is consistent with someone trying to do chest compressions as confirmed by the crew/practitioner on scene. Crew asked the day staff to see if the night staff checked on the patient and may have performed CPR. The day staff then stated that the night staff did not pass any details of any significant activities.*"

16. The safeguarding referral went on to say that the bruising was likely to have been caused by a fractured sternum. The Council's records note a telephone call from an adult safeguarding nurse at the hospital where Mrs H was admitted, saying medical staff thought the bruising was one to three days old and had been caused by "*external forces*". The records confirm Mrs H would not return to Rose Court.

17. The Council's safeguarding officer visited Rose Court the same day and collected copies of the daily logs, body maps and charts. She told the social worker there were no falls logged in the previous week which would explain the injuries.

18. The safeguarding officer also told the care provider that Mrs H would not return to Rose Court and the Council was terminating its contract for her with immediate effect. Later that day the care provider emailed the Council to say it appeared from the termination of the placement that blame had already been apportioned. The care provider said it would accept notice on the usual contractual terms, but added that (with the sale of her property) Mrs H actually became self-funding from 1 September.

19. In accordance with the multi-agency safeguarding procedures, the police led the investigation into Mrs H's injuries. The Council's records note a telephone call between the social worker and a CQC inspector in which she told him that several medical staff had queried whether the "*hand-shaped*" bruising on Mrs H's chest had been caused by an

attempt at CPR. She told him the care provider said it did not have any records for 28 and 29 August. It said this was because staff did not have the relevant forms to complete.

20. On 5 September the police interviewed all staff who had been on duty during the timeframe when the injury might have been caused. The police did not find any new evidence. The visiting community nurse confirmed to the Council that the care at the home was generally good although she said the care provider was poor at keeping records and updating care plans.

21. Mrs H moved into a nursing home in September.

22. The orthopaedic evidence obtained during the safeguarding investigation suggested that the fracture to Mrs H's sternum could have occurred in the 6 week period before the bruising showed, and become dislodged on 28 August when Mrs H complained of pain. The social worker asked the hospital safeguarding nurse in October to check whether Mrs H's chest had been x-rayed during a previous admission for a fall in July.

23. In March 2015 the social worker contacted Mrs B to explain that there had been a significant delay in obtaining the hospital records, but she said it was now clear that when Mrs H had fallen in July and been taken to hospital, no chest x-ray had been performed.

The outcome of the safeguarding investigation

24. The social worker met the care provider at the home in May 2015. She then spoke to Mrs B. She explained that the outcome of the safeguarding investigation was inconclusive: the allegations were partially substantiated, as it was deemed there had been "*acts of omission*", but no evidence that wilful neglect had caused the fracture. The social worker acknowledged how frustrating it was not to be able to identify the incident which had caused the fracture. She explained to Mrs B that the care provider had been asked to formally respond in writing to her.

25. In June the care provider wrote to Mrs B in response to the concerns she had raised. It said all the lifting equipment at the home was in order and maintained regularly. It said although the sling used to move Mrs H was not individual to her, it was appropriate for her and all staff were trained in its use. It went on, "*Staff employed at Rose Court Lodge have not been able to categorically state how (Mrs H) received the injury leading to her admission to KMH on 29 August 2014. They have been interviewed by the Police in accordance with safeguarding legislation and the outcome of this investigation was inconclusive in relation as to how the injury was caused. However, the staff on duty on the morning of 29 August 2014 were both concerned and upset that there was unidentified bruising found to Patricia's chest area and acted accordingly*".

26. The care provider went on to say that although ambulance and emergency department staff had made assumptions that the bruising had been caused by attempted COR, this was "*immediately denied*" by the senior carer on duty who said it was not company policy to attempt CPR, and no member of staff would have attempted it. It reiterated that no x-ray of the chest had been undertaken at the time of Mrs H's fall in July so it could not rule out the possibility, as suggested by the orthopaedic consultant, that the fracture occurred then. The care provider offered unreserved apologies to Mrs H and her family for the distress caused.

27. Mrs H sadly died in August 2015

28. Mrs B remained dissatisfied with the response from the care provider and the outcome of the safeguarding investigation and complained to the Ombudsman.

The Council's response

29. The manager responsible for elderly residential care said he was unclear why Mrs H had not been moved when Mrs B first asked, as he said that was a decision

usually dictated by families. He points out that the Council would not usually make a decision to move someone from a care home where there were trusted family members who could act on the resident's behalf.

30. The Council acknowledges there were shortcomings on the part of the care provider, particularly in respect of record-keeping.

Analysis

31. It is not possible to say now how the injury to Mrs H occurred. There were conflicting views even at the time of her hospital admission.

32. However, there are concerns about Mrs H's care and treatment in the home. There are no records of Mrs H's care in the two days before her hospital admission. That is unacceptable, and is a breach of the standards in place at the time which required clear, accurate and up-to-date recording. The consequence of the lack of records is that it was not possible to discern whether Mrs H incurred the injury then, or dislodged an old fracture.

33. The care provider (acting on behalf of the Council) also failed to call for medical attention promptly to Mrs H when she was in pain. Again, there are no records from the home to show why this was so. The safeguarding alert records that Mrs H was in pain when the morning staff found her, but the night staff had not passed on any information about her condition despite her pain the previous evening. That was fault which caused Mrs H injustice.

34. The safeguarding investigation was conducted promptly but could not find any conclusive evidence that Mrs H had been the victim of wilful neglect, although the allegation of acts of omission was partially substantiated.

35. After it received my draft statement, the Council provided additional details of the monitoring it was undertaking to secure an improvement in standards at the home.

36. There is no evidence that the Council refused to move Mrs H from the home.

Agreed action

37. The Council remained responsible for Mrs H's care while it funded her placement and agrees, within one month of this final decision, to apologise to Mrs B for some poor standards of care and treatment Mrs H received in the home.

38. The Council agrees to offer a payment of £500 to Mrs B within one month of this final decision in acknowledgement of the distress caused to her by the knowledge that harm did happen to Mrs H in the home and that the safeguarding process identified acts of omission.

Final decision

39. There was fault on the part of the Council which caused injustice to Mrs H and Mrs B.

Investigator's decision on behalf of the Ombudsman

25 October 2016

Complaint reference:
16 003 825

Complaint against:
Nottinghamshire County Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: There was no fault in the Council's handling of Mr B's concerns about his children. The Council was at fault for saying in a letter that it was unaware of one of Mr B's referrals. That point did not cause any significant injustice.

The complaint

1. The complainant, whom I shall refer to as Mr B, complains the Council failed to take safeguarding action or investigate his referrals about his children's care.

The Ombudsman's role and powers

2. The Ombudsman investigates complaints of injustice caused by maladministration and service failure. I have used the word fault to refer to these. The Ombudsman cannot question whether a council's decision is right or wrong simply because the complainant disagrees with it. She must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, section 34(3))***

3. The Ombudsman provides a free service, but must use public money carefully. She may decide not to start or continue with an investigation if she believes the fault has not caused injustice to the person who complained, or the injustice is not significant enough to justify her involvement. ***(Local Government Act 1974, section 24A(6))***

How I considered this complaint

4. I considered the information Mr B provided. The Ombudsman's office made written enquiries of the council and I considered the response and relevant Council records. I gave the Council and Mr B the opportunity to comment on my draft decision. I propose to share this decision statement with the Office for Standards in Education, Children's Services and Skills (Ofsted).

What I found

5. Mr B is separated from the mother of his two children. I shall refer to his son as S and to his daughter as D. The children lived with their mother or her parents at the time of the events complained of.

6. Mr B is unhappy with the Council's handling of points he raised about the children's care. He told the Ombudsman he wanted the Council to remove the children from their mother's care. Councils can normally only remove children from a parent if a court orders this. The Ombudsman cannot tell the Council to do this. The Council decided Mr B's concerns did not warrant it taking any formal

child protection action. I can only consider whether the Council properly reached its decisions. For confidentiality reasons I cannot share much with Mr B about the details of the Council's actions here, some of which involve other people or agencies.

7. In February 2016, Mr B alleged to the Council that different men had been present at his ex-partner's home, there had been drug use there and he was concerned about how this affected his son's mental health. Mr B also referred to previous family court proceedings. For confidentiality reasons I cannot go into detail about what the Council did but I am satisfied it acted on and considered what Mr B said. The Council decided there were no grounds to take further child protection action.

8. I consider the Council properly reached this decision. So, while Mr B can disagree with the Council's decision, I cannot criticise that decision, as paragraph 2 explained.

9. On 22 April 2016, Mr B told the Council he was concerned S had acted in a sexually inappropriate way towards D and that S had viewed pornography. Mr B had also told the police this. Mr B stated he had been told about both these incidents three or four months earlier.

10. I am satisfied the Council considered and acted on this, including speaking to S's mother. The Council concluded it would do some work with S about his having viewed pornography but beyond that no further child protection action was needed.

11. I consider the Council reached this decision properly in the circumstances. So I shall not pursue this point any further.

12. On 29 April 2016 Mr B made another referral to the Council, making the same points as in his previous two referrals. The Council decided there was nothing new in those points. I see no fault in that, as far as it went.

13. On 3 May 2016 Mr B contacted the Council again, reporting D had been swearing recently, including racist language. He alleged his ex-partner had admitted teaching D to swear. The Council said it would add this to the referral Mr B had made on 29 April. On 9 May Mr B reiterated to the Council by telephone that D had sworn and made a racist comment, which Mr B suggested could be connected to views he believed his ex-partner's new partner held.

14. The Council's records show the Council took action on this report and concluded there were no safeguarding concerns so no need for further child protection action. I am satisfied this was a decision the Council was entitled to make and was properly reached. The behaviour Mr B described was obviously very undesirable but the Council is entitled to consider it is not actually a child protection matter.

15. However, the Council's response to Mr B's complaint on 14 June 2016 said it could find no reference to allegations of racist language in Mr B's referrals of 22 and 29 April. I consider this was fault as the Council's own records said it would add this point to the referral of 29 April. However, I am satisfied the Council had considered this allegation, as I explained above. The inaccurate complaint response seems to have resulted from different officers not knowing what each other had done.

16. In addition, the Council's response to the complaint said that, although racist language is wrong, this would not be a child protection matter meriting Council

involvement and Mr B could instead discuss it with his ex-partner and the school. There is no fault in that. So, while the Council's fault in stating it could not trace the allegation of racist language could have caused Mr B some frustration, I do not consider it caused a significant injustice because the Council dealt with the underlying matter, which was not going to trigger child protection action anyway.

Other concerns Mr B raised

17. Mr B has suggested the Council was involved in S's moving from his mother's home to live with his grandparents. I have seen no evidence of that.

18. Mr B's formal complaint to the Council included that a Council officer had not returned his telephone calls or did not do so promptly enough. The Council disputes this. Anyway I do not consider this point disadvantaged Mr B significantly enough for me to pursue it.

19. Mr B's complaints also asked the Council whether a social worker had been working with his ex-partner and children. Even within a family, people are not necessarily entitled to know the answer to such questions about other people. So I have not considered this point further.

20. In June 2016 Mr B asked the Council for help visiting his son, including for a social worker to accompany him. The Council declined, saying this was not the role of social workers as the Council had no child protection involvement and if Mr B had any safeguarding concerns he could report them to the Council. I see no fault here.

Final decision

21. I have not found fault by the Council on the substantive points of the complaint. There was some fault as paragraph 15 described but this did not cause any significant injustice. So I have ended my investigation.

Investigator's decision on behalf of the Ombudsman

12 September 2016

Complaint reference:
15 020 802

Complaint against:
Nottinghamshire County Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: The Council was at fault by failing to communicate with Ms B over her disabled son's care, involving a safeguarding concern, a core assessment and a review, and arrangements for his transition to 18+ education. It also delayed providing a personal budget to cover the cost of paying a driver to take her son to and from school.

The complaint

1. The complainant, whom I shall refer to as Ms B, complained that there had been faults in the way the Council's Children's Disability Services Team dealt with her son. These included a safeguarding concern, transition to a new school, a core assessment and a request to provide a direct payment for his transport to school.

The Ombudsman's role and powers

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

How I considered this complaint

3. I have taken account of Ms B's complaint to the Council and its letters in response to the complaint. I also studied a copy of the minutes of a meeting attended by Ms B with two managers from the service and a complaint officer in October 2015.
4. I examined the details of the Council's initial assessment and then its core assessment carried out on Ms B's son (who I shall refer to as C.)
5. I sent copies of a statement setting out my provisional decision to Ms B and the Council and I invited them to comment. As a result of Ms B's reply I then asked the Council for additional information which I considered fully before reaching my final decision.

What I found

6. C is now 18 years old. The events of the complaint all took place before he reached his eighteenth birthday. He has a learning disability and a psychological/eating disorder and he finds it difficult to communicate clearly. He often expresses himself by drawing pictures and trying to explain them.

7. During early 2015 C was in year 12 at his school. Ms B did not believe the school was by then able to meet C's needs and staff did not understand his medical disorder. She had applied for a place at a nearby college (College H) which has a unit for people suffering from the particular disorder. C had been attending College H once a week whilst in year 12, along with some other students from his year group.

The safeguarding issue

8. C had previously alleged that another boy had touched him inappropriately in school towards the end of 2013. There was no conclusive evidence to prove the allegation but staff said they had made sure the two boys were never left alone together after that. In December 2014 C attended a learning day at College H. The other boy also attended and the Council said both boys were closely supervised by teaching assistants all day. C later complained that the other boy had again touched him in his genital area. The teaching assistants were interviewed as part of an internal school investigation. They both reported they felt this would have been impossible as both boys were closely supervised throughout the visit.

9. Later, during a session with a teaching assistant, C produced some drawings and said they showed what had happened to him during the college visit. Ms B also said he told her about the incident whilst having a bath at home. The Council's officers and the school staff remained unsure whether the incident did occur or whether C was drawing on his memories of the original incident. It is clear there was no other evidence available to either prove or disprove C's allegations.

10. As a result of the allegation C was referred to a multi-agency safeguarding hub and a social worker carried out an initial assessment and a core assessment. Ms B had not seen these until she attended a meeting with Children's Disability Service Managers in October 2015. Ms B believed the safeguarding investigation had been shoddy and incomplete as the teaching assistant involved in the drawing session had not been interviewed by the Council. The manager responsible for C's care services apologised to Ms B for the failure to provide her with the assessments.

11. The Council can initiate an investigation under section 47 of the Children Act 1989 if it believes a child may be at risk of significant harm. In this case the Council did not do this. It was aware of one confirmed incident in the past when C had been improperly touched and a second, uncorroborated incident. The Council was satisfied the school had taken action to keep C and the other boy apart and the risk of a further such incident was thought to be highly unlikely. The Council could have carried out an investigation but it was satisfied by the school's own investigation that C was not at risk of ongoing harm. On that basis the decision not to go ahead with a section 47 investigation was based on professional judgement and I do not question it.

Lack of communication over C's transition to College H

12. The Council accepted that this had been the case. It was the result of staffing shortages within the service. The manager apologised for this failing and said C had not had regular or effective reviews of his case. She confirmed he should have had a Child in Need Review twice a year after which revised plans should have been put in place. She accepted the department should have been working closely with Ms C and helped more with his transition to 18+ education.

13. Ms B said she had made an enquiry about taxi costs to take C to school but nobody responded. She was anxious that C did not have to move into residential care and sought a review of a direct payment to her on C's behalf.

Failure to carry out a core assessment for C

14. The Council accepted this should have been done sooner than it was. Ms B was given a copy of the assessment during the meeting in October 2015.

Direct payment for C's transport to school

15. C was taken to and from school by taxi which was paid for by the Council. The Council changed the contract to another taxi firm and C did not know the new driver so he refused to travel in the taxi. Ms B asked the Council to consider providing C with a personal budget which would cover the cost of employing their own driver. The Council accepts it did not respond to that request at the time.

16. Ms B or her mother then had to drive C to and from school. This caused them inconvenience and they had to pay for their own fuel. Ms B asked the Council to repay £2100 to cover what it would have cost them to employ a driver over a 14 week period. The Council refused this request as they had not actually paid anyone. Instead it offered £560 to cover the cost of fuel they had used.

17. Following this the Council did award C a personal budget and Ms B now employs a driver to take and collect C each day.

Fault and injustice

18. Following C's allegation that he had been inappropriately touched by another student, the Council did not communicate well with Ms B and took too long to provide her with the assessment reports that were produced in response to the incident. The Council apologised for this and provided Ms B with the relevant report.

19. The Council accepted it failed to communicate with Ms B over C's intended transition to 18+ education. It also failed to carry out regular or effective reviews including a Child in Need Review, which should have led to a revision of C's plans. Ms B was anxious at that time that C might have to move into residential care and the Council could have done more to resolve those concerns.

20. The Council did not respond to Ms B's request for a personal budget to cover C's transport costs. This led to her and her mother transporting him to school at their own cost. C was later allocated a personal budget and it is reasonable to assume this would have happened sooner if the Council had responded to the request. The Council accepted this was fault and offered Ms B £560, representing the cost of her fuel over the 14 weeks in question.

Agreed action

21. I am satisfied that Ms B's request to be paid £2100 was not based on any actual financial loss and I do not support the request. I regard the offer to pay £560 to cover the cost of fuel used to take C to school as a fair offer.

22. The Council has also agreed to offer Ms B the additional sum of £200 to address her inconvenience, her frustration at not receiving information she should have been sent, and her time and trouble in pursuing the matter.

Final decision

23. The Council was at fault through poor communication relating to C's care and failing to send information to Mrs B at the correct times. It also delayed carrying out C's Child in Need Review and agreeing to give him a personal budget for transport which caused injustice to his mother, Ms B.

24. It has made a fair offer to cover her fuel costs and apologised to Ms B for its failings. I believe this, together with the additional agreed payment of £200, will provide a fair and proportionate remedy for the complaint.

Investigator's decision on behalf of the Ombudsman

17 August 2016

Complaint reference:
15 016 837

Complaint against:
Nottinghamshire County Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: The Council is at fault as it wrongly told Mr X that it would exclude bids for a contract on turnover alone. As a result Mr X was caused some uncertainty which the Council has agreed to remedy.

The complaint

1. Mr X has complained that the Council wrongly excluded him from bidding for a contract on the past turnover of his company.

The Ombudsman's role and powers

2. The Ombudsman investigates complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. She 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, she may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1))***

How I considered this complaint

3. I have:

- considered the complaint and the information provided by Mr X;
- discussed the issues with Mr X;
- made enquiries of the Council and considered the information provided;
- invited Mr X and the Council to comment on the draft decision.

What I found

4. In 2015 the Council commenced a tender process for the maintenance of a website. The Council's invitation to tender (ITT) included qualifying criteria to enable the Council to assess the suitability of a bidder to provide the contract. The criteria was of a pass/fail nature. The ITT states that a fail in one or more of the criteria would provide grounds for exclusion from further consideration.

5. One criterion stated:

"*The estimated value of the contract should not exceed 50% of the average turnover of the company or organisation as determined from their financial accounts for the last two years. If accounts or other relevant information is not available and or concerns remain over financial liability that cannot be reasonably satisfied then it is likely you will fail. Third party credit checks will also be undertaken as part of a financial assessment. A poor credit rating which scores 3*

or more in a Dunn & Bradstreet check may lead to further clarification that may result in a fail."

6. The tender process included a clarification stage during which potential bidders could request clarification on the ITT. The Council sent question and answer sheets to potential bidders so they could see the questions asked and the Council's response.

7. A potential bidder asked for details of the estimated value of the contract and whether the Council would consider bids from suitably qualified providers who might submit a significantly competitive bid. The Council's reply was:

> *' we assume you are asking with reference to financial turnover. The turnover is pass/fail.'*

8. Mr X questioned if the Council was able to request that the estimated value of the contract should not exceed 50% of a company's turnover as he considered this was contrary to Government guidance. The guidance states that turnover may be a useful indicator of capacity but issues of financial position, capacity and capability should also be considered. It also states that authorities should not impose arbitrary minimum requirements which may have the unintended consequence of preventing new businesses from bidding.

9. The Council said it did not consider the turnover criterion to be unreasonable as the estimated value of the contract was fairly low. The Council also said:

> *'if this criteria is not met the bidder will fail this element and not be considered'*

10. In response to a further clarification from Mr X, the Council told him that his turnover would need to be twice the three year value of the contract price he bid.

11. Mr X did not submit a bid for the contract as he considered his company would be excluded on turnover. He made a complaint to the Council about its decision to set the turnover criterion.

12. The Council did not uphold Mr X's complaint. The government regulations for contracts allow councils to impose a minimum turnover criterion but this must not exceed twice the estimated contract value. The Council considered it could impose the minimum turnover criterion as it did not exceed twice the estimated value of the contract.

13. In response to my enquiries the Council has said it did not reject bids based on turnover alone so it acted in accordance with the Government guidance. The Council conducts financial assessments of suppliers The Council has acknowledged that there may have been some miscommunication in the clarifications which focussed on turnover.

14. Mr X has provided evidence to show the contract has now been let.

My assessment

15. The Council informed Mr X during the clarification process that his bid would fail if he did not meet the turnover criterion. This information was incomplete as the Council did not intend to reject bids on turnover alone. This is fault. Mr X could have submitted a bid. However, the incomplete information provided by the Council may have discouraged him from doing so.

16. Mr X says he has suffered a loss as a result of the Council's fault as he considers on the balance of probabilities that he would have won the contract. He is seeking a remedy based on the sum of he would have bid for the contract. This is not an

appropriate remedy. This is because I cannot know, on balance, if Mr X would have won the contract if he had submitted a bid. But Mr X will never know so the fault has caused him some uncertainty which the Council should remedy.

Agreed action

17. That the Council makes a payment of £500 to Mr X to acknowledge the uncertainty caused to him by the provision of incomplete information suggesting it would exclude bids for a contract on turnover alone.

Final decision

18. The Council is at fault as it wrongly told Mr X that it would exclude bids for a contract on turnover alone. As a result Mr X was caused some uncertainty which the Council has agreed to remedy by making a payment of £500 to Mr X. This is an appropriate and proportionate remedy for Mr X's complaint so I have completed my investigation.

Investigator's decision on behalf of the Ombudsman

4 August 2016

Complaint reference:
15 020 183

Complaint against:
Nottinghamshire County Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: the Council was not at fault for how it assessed Mr B and his wife as carers for their grandson. However, the Council failed to respond to proposals from family members, failed to arrange a family group conference and failed to involve Mr B in meetings. An apology and changes to procedures is satisfactory remedy for the injustice caused.

The complaint

1. The complainant, whom I shall refer to as Mr B, complained about the way the Council dealt with care proceedings for his grandson. Mr B complained the Council:

- failed to properly consider him and his wife as carers for his grandson;
- relied on inaccurate social work records when deciding he and his wife were not suitable carers for his grandson;
- failed to consider proposals from his son and elder daughter to enable his grandson to remain in his care;
- failed to conduct a family group conference; and
- failed to properly communicate with him or his wife or involve them in meetings.

The Ombudsman's role and powers

2. The Ombudsman investigates complaints of fault where someone says it has caused them injustice. If the Ombudsman finds fault but no injustice, she will not ask a Council to provide a remedy. If she finds both fault and injustice, she may ask for a remedy. She can consider the way an authority makes its decisions, but it is not her role to comment on them unless they have been taken with fault. ***(Local Government Act 1974, sections 26(1), 26A(1) and 34(3))***

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

How I considered this complaint

4. As part of the investigation, I have:

- considered the complaint and Mr B's comments;
- made enquiries of the Council and considered the comments and documents the Council provided;

- considered Mr B's comments on my draft decision; and
- considered the Council's comments on my draft decision.

What I found

Background

5. The Council received a referral in October 2014 about Mr B's daughter allegedly staying in a property with her son where drugs were being taken. Mr B says at the time his daughter and grandson were living with him and his wife. Mr B and his wife had also recently been diagnosed with cancer.

6. Following Mr B's daughter being arrested for drug use while caring for her son the Council decided it was not safe for the child to remain with his mother. As the Council had concerns about whether Mr B and his wife could prioritise their grandson over their daughter the Council placed the child with Mr B's son. When that arrangement could no longer continue the Council placed the child in foster care, pending court proceedings to consider his future.

7. The Council completed a viability assessment on Mr B and his wife as well as assessments of Mr B's daughter and the child's father. The viability assessment for Mr B and his wife was negative. The assessment of Mr B's daughter was also negative. However, the assessment of the father of the child was positive. The child moved in with his father in July 2015, at the end of court proceedings.

Analysis

8. I have found no evidence to suggest the Council failed to properly consider Mr B and his wife as carers for his grandson. Once the Council had decided Mr B's grandson could not be returned to his mother's care the Council began the process of assessing those who could potentially care for the child. That included assessments of the child's father and partner as well as viability assessments for Mr B and his wife. I understand Mr B believes the Council did not properly consider him due to what it included in the viability assessment. Mr B says prior to the viability assessment the Council had referred to him and his wife as a stabilising influence. He says despite that the viability report completed for the court made assumptions about their ability to care for their grandchild and ignored medical evidence. As I said in paragraph 3, the Ombudsman does not have jurisdiction to consider matters which have been adjudicated on by a court. I understand the report Mr B is concerned about is the viability assessment which was presented to the court. If Mr B had concerns about the contents of that report and its accuracy he would have needed to address those points in court. I therefore cannot comment on the contents of the report.

9. I am aware though when the Council decided Mr B's grandson could no longer remain in his mother's care it did not place him temporarily with Mr B and his wife. I understand Mr B's concern about that given his daughter and grandson had lived with him for some time. However, the documentary records show social workers had concerns about whether Mr B and his wife could prioritise their grandson ahead of their daughter and adequately protect him. I understand Mr B strongly disagrees with that view. However, as I said in paragraph 2, it is not my role to comment on an officer's judgement. As the social work records contain concerns about placing the child with Mr B and his wife prior to court proceedings I cannot criticise the Council for seeking an alternative placement while it conducted its enquiries.

10. Nor can I criticise the Council for not completing a new assessment when Mr B's wife died in May 2015. By that point the Council had already completed a viability assessment of Mr B and his wife which was negative. In addition, the Council had completed an assessment of the father and that assessment was positive. In addition, Mr B's grandson had expressed a wish to live with his father. Given court proceedings were already advanced and the assessment showed concerns relating to Mr B's ability to protect his grandson, as well as concerns about his wife, I do not criticise the Council for not starting the process again.

11. Mr B has some concerns about the content of the viability assessment. In particular, Mr B says the assessment presents opinion from other people as if it is fact and also misquotes him. Mr B says the Council has done that to undermine its assessment of him. While I understand Mr B's concern, the viability report was completed for court proceedings. Had Mr B wanted to challenge the contents of the viability assessment he would have needed to do so in court. As that is the case I cannot comment on Mr B's concerns about the report completed for court proceedings.

12. The situation is different in relation to the social work recordings though. Mr B says those social work records are inaccurate, particularly where they refer to concerns Mr B was colluding with his daughter. Mr B says that is not accurate because that concern was in relation to his wife, rather than Mr B. I understand Mr B's concern. There are more references in the social work records to concerns about Mr B's wife colluding with her daughter than to Mr B colluding. However, there are also references to Mr B colluding with his daughter. In addition, the social work records show social workers had concerns about Mr B's ability to prioritise his grandson over his daughter. I know Mr B disagrees with some of those judgements. However, it is not my role to comment on an officer's judgement.

13. Mr B says the Council claimed it had a set deadline to return his grandson to his son's care on 19 January 2015 when that is not the case. On that day the Council says a social worker arrived at school to collect the child only to find Mr B and his daughter already there, intending to take the child to a GP appointment. Mr B says that is incorrect and he went to the school to resolve an impasse between his daughter and the social worker. At that time the child was in the care of the uncle due to concerns about Mr B's daughter's activities. Having considered the documentary records there is nothing to suggest the Council said it had provided Mr B with a set deadline to return his grandson. However, it is clear from the documentary records the Council had not expected anyone to collect the child for his GP appointment on the day in question. It is also clear the social worker was in regular contact with Mr B asking him to return the child to the uncle's house. As I have seen no evidence to suggest the Council has described what happened in terms of when the child should be returned to his uncle's care any differently to what is supported by the documentary records I have no grounds to criticise it.

14. Mr B says the Council failed to consider proposals from his son and elder daughter which would have allowed his grandson to stay in the care of his maternal family. Mr B says that proposal would have meant the least disruption for his grandson. The Council admits it failed to respond to those proposals. That is fault. I could not say if the Council had replied to those proposals it would have resulted in a different outcome though. That is because the Council already had concerns about whether it was appropriate to place the child in his grandparents' care. In addition, both Mr B's son and his elder daughter had said they could not provide long term care to the child. As well as that, the Council would have had to

consider whether to place the child with his father. Nevertheless, the Council should have responded to the proposal and explained why it did not consider it a viable option. Failure to do that is fault. I understand why, in those circumstances, Mr B may have felt the Council had already made up its mind. However, as I have made clear, the evidence I have seen satisfies me the Council already had concerns about placing the child in his grandparents' care by that point.

15. Mr B's elder daughter had also asked the Council to arrange a family group conference. I understand that is something social workers had told Mr B would take place. The Council accepts it should have considered whether a family group conference was necessary. Failure to do that is fault. Again though, I could not say that would have resulted in a different outcome given the Council's concerns about placing the child in the grandparents' care.

16. Mr B says the Council failed to share information with him about the nature of its concerns. Mr B says because the Council did not share full information he did not properly understand the Council's concerns and may therefore have appeared uncooperative. I understand Mr B's point. However, at the outset of the investigation the Council only had an allegation about Mr B's daughter. It had no information at that point other than the referral. The information the Council had was specific to Mr B's daughter and it was for the Council to decide how much information it could share about that without breaching the Data Protection Act. In this case it is clear limited information was given on the first contact. On balance I do not criticise the Council for that because it was still investigating and had not established where Mr B's daughter and her child lived. Consequently the Council was not in a position at that point to establish whether it needed to share information with the grandparents' to prevent any harm to a child.

17. I am satisfied though that when the Council visited Mr B's address on 13 November 2014 to discuss matters with his daughter, Mr B and his wife were present. Mr B does not recall such a visit but the notes from that discussion record Mr B's wife interjected during discussion about the Council's concerns. I am therefore satisfied the Council shared more information at that point.

18. I am aware Mr B is also concerned about documentation not being shared with him. Again though, the Council has to comply with the Data Protection Act. I am satisfied the Council shared the detailed assessments once the court gave it permission to do so. I therefore do not criticise the Council here.

19. I agree with the stage two investigator though that Mr B and his wife should have been invited to meetings about their grandson. Mr B and his wife were clearly significant family members in their grandson's life and could have provided relevant information to the meetings which took place. The Council is therefore at fault for not inviting them, although I am aware Mr B attended some meetings of his own volition.

Agreed action

20. the Council has:

- apologised for the failure to respond to his son and eldest daughter's correspondence;
- apologised for failing to undertake a family group conference when it had undertaken to do so;
- apologised for the failure to invite Mr B to looked after child reviews;

- agreed to remind staff of their duty to make records of all contacts on a live case and ensure response letters are sent within 10 working days; and
- agreed to review its policy and practice on family group conferences to ensure it acts in accordance with government guidance.

21. I consider the action the Council proposes to take a reasonable outcome for the complaint. That is on the basis of my view that it is unlikely, on the balance of probability, the outcome would have been different had the fault identified not occurred.

Final decision

22. I have completed my investigation and found fault by the Council in part of the complaint which caused injustice to Mr B. Although Mr B does not agree with my decision I am satisfied the action the Council will take is sufficient to remedy his injustice.

Investigator's decision on behalf of the Ombudsman

22 July 2016

Complaint reference:
15 017 364

Complaint against:
Nottinghamshire County Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: Mr C complained the care provider left his daughter alone at home unsupervised on one occasion. The care provider's complaint investigation found there was fault, which had resulted in an injustice to Ms D and her parents. I found that the apology that Mr C received was an appropriate remedy for the injustice.

The complaint

1. The complainant, whom I shall call Mr C, complains that a care worker from the care agency the Council commissioned, put his daughter (and his property / belongings) at great risk. In July 2015, he and his wife had been unable to return home on time. They arrived five minutes late and saw the care worker had already left. The door was unlocked and she had left their daughter alone and unsupervised. Mr C says he wants the Council to pay a financial remedy for the distress he and his daughter suffered because of this incident, as anything could have happened.
2. Mr C is also unhappy the care provider discontinued his complaint even though he had not reached the end of the complaints procedure yet.

The Ombudsman's role and powers

3. The Ombudsman investigates complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. She 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, she may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1))***

How I considered this complaint

4. I considered the information I received from Mr C and the Council. I shared a copy of my draft decision with Mr C, the Council and the Care Provider and considered any comments I received before I made my final decision.

What I found

5. The Council commissioned the care provider to provide support to Mr C's daughter, whom I shall call Ms D. As part of this, Ms D receives a few hours of respite care once every four weeks. This enables Mr C and his wife to have a break from their caring duties. However, on this particular occasion, Mr and Ms C had been unable to return home on time. Even though they only arrived five

minutes late, the care worker had already left. The care worker had left his daughter unsupervised in an unlocked property, even though she needs constant supervision. His daughter has the mental age of an eight year old and was in tears when they arrived home.

6. In its response to Mr C's complaint, the care provider admitted it had been at fault. It explained the care plan and the written instructions for the care workers were inadequate as it does not say that Ms D should be supervised at all times. It said the referral information and risk assessment information it received from the Council did not refer to this. Nevertheless, the care provider acknowledged it should have ensured that enough instructions and risk assessments were in place for staff to follow, as soon as it agreed to deliver the support. It also told Mr C about the action it has undertaken to avoid a similar even from happening again.

7. Mr C told me his wife had told the care worker not to leave their daughter on their own.

8. The Council says that Ms D's needs are recorded in the assessment and support plan. The assessment and support plan completed in early 2015 clearly state all the risks related to Ms D. Although not mentioned specifically, the Council says these clearly indicate Ms D needs continual oversight. However, it accepts the communication between the Council and the care provider about Ms D's care package was at times confusing. The outcome of the investigation was that the care provider left Ms D at risk and the allegation was substantiated, because her risks were not managed when the care worker left.

9. Mr C told me he was also unhappy with the way the care provider handled his complaint. He says that he never agreed to discontinue his complaint, as maintained by the care provider. Mr C told me the care provider tried to organise a meeting with him. As such, Mr C says he asked the care provider in an email on 13 January 2016 to confirm if their meeting would be at his home or somewhere else. However, he never received a response to this.

10. The care provider sent a letter to Mr C on 14 December 2015. It says that: "*This is a note to follow up on our telephone conversation on Friday 4 December 2015. You advised me at that time that you do not wish to pursue your original complaint. Therefore in accordance with our policy if I do not hear from you within the next 7 days I will close the complaint*".

11. Mr C sent a copy to me of the email he sent on 13 January 2016. However, there was a small error in the email address he used, which is why the care provider never received it.

12. Mr C told me that he was also unhappy that, when he wanted to bring his complaint to the Council, it told him in February 2016 that it cannot investigate his complaint, because its policy says that it will ask the concerned care provider to investigate and provide a response.

13. The Council told me that, when it receives a complaint about a care provider it has commissioned, it will ask the care provider to investigate it. However, the care provider had already carried out two investigations (stage 1 and stage 2) and had offered Mr C to escalate it to stage 3, if he remained unsatisfied. The Council therefore refused to accept the complaint, because it appeared it had already been appropriately dealt with by the care provider. The Council also told Mr C in its response about the LGO.

Assessment

14. The Council and the care home had already acknowledged there were shortcomings with regards to the communication between them, in this particular case. In addition, although the risks identified in the support plan indicate Ms D's need for continual oversight, it would have been better if it had specified that Ms D should be supervised at all times and not be left alone.

15. When there has been fault, as there has been in this case, the remedy that should be offered to the complainant should be for the actual injustice the complainant(s) suffered; it should not be for anything that could have happened. In this case, the injustice caused to Ms D was that she became distressed when she was left alone. The incident also caused distress to her parents. I found that the apology that was provided was an appropriate remedy for the injustice Ms D and her parents suffered.

16. I did not uphold Mr C's complaint about the way in which the care provider and the Council dealt with Mr C's complaint. However, legislation in relation to complaints about adult social care that is provided (or commissioned) by councils, indicates there should only be one investigation into complaints (i.e. one stage). This was not the case with regards to Mr C's complaint as the care provider has a three stage process. The Council therefore needs to ensure that adult social care providers only carry out one thorough investigation, when the complaint is about care commissioned by the Council.

Agreed action

17. I recommended the Council should ensure that the care providers it uses carry out only one thorough investigation, when the complaint is about care commissioned by the Council, after which it should inform the complainant of their right to refer the complaint to the Ombudsman.

18. The Council has accepted my recommendation.

Final decision

19. For the reasons mentioned above, there was fault that resulted in an injustice to Ms D and her parents, which has been appropriately remedied through an apology. The Council has accepted my recommendation and I have therefore closed the complaint.

Investigator's decision on behalf of the Ombudsman

16 May 2016

Complaint reference:
15 004 855

Complaint against:
Nottinghamshire County Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: there is no fault in how the Council dealt with a discharge from hospital. Documentation for a care assessment was inadequate. An agreement to ensure care assessments record the Council's reasoning is satisfactory remedy for the injustice caused.

The complaint

1. The complainant, whom I shall refer to as Mrs B, complained the Council:

- reduced her aunt's direct payments, resulting in her aunt falling and breaking her ankle;
- failed to consider her appeal against the reduction in care;
- forced her aunt to go into a care home;
- told her aunt the stay would be short term and then closed the file.

The Ombudsman's role and powers

2. The Ombudsman investigates complaints of injustice caused by fault. She can consider the way an authority makes its decisions, but it is not her role to comment on them unless they have been taken with fault. ***(Local Government Act 1974, section 34(3)***

How I considered this complaint

3. As part of the investigation, I have:

- considered the complaint and Mrs B's comments;
- made enquiries of the Council and considered the comments and documents the Council provided
- considered Mrs B's comments on my draft decisions;
- gave the Council an opportunity to comment on my draft decisions; and
- interviewed the officers that carried out the May 2014 assessment.

What I found

Chronology of the main events

4. In March 2013 the Council assessed Mrs B's aunt as requiring 44.7 hours care per week. In March 2014 the Council carried out a review which assessed Mrs B's aunt as requiring 31.75 hours per week. The new care package was to start on 25 April.

5. Mrs B put in an appeal and the Council carried out a review at the end of May 2014. At that point the Council increased the care provision to cover 33 hours 30 minutes per week. That began on 28 July.

6. On 18 January 2015 Mrs B's aunt was admitted to hospital following a fall.

7. A Council social worker visited Mrs B's aunt in hospital on 21 January Mrs B's aunt said she did not think she would manage at home and preferred a short-term placement in her area. I will refer to that as placement A.

8. On 22 January the Council social worker met with Mrs B's aunt and family members at the hospital. Mrs B's aunt agreed to go into short-term care. Mrs B's aunt asked about how to pay for that care on 26 January. A Council social worker explained the Council would carry out a financial assessment.

9. On 27 January the hospital discharged Mrs B's aunt to a care home, which I will refer to as placement B. The Council could not place Mrs B's aunt in placement A as there were no places available.

10. On 30 January a family member contacted the Council to say Mrs B's aunt wanted to return home and needed more support. The Council later reassured the family the case was not closed and Mrs B's aunt would be allocated a worker to arrange any additional support so Mrs B's aunt could return home.

11. A social worker contacted Mrs B's aunt on 5 February to arrange the review. Mrs B's aunt said she wanted her son and Mrs B present. The social worker agreed to contact them to arrange the review.

12. The social worker contacted Mrs B on 9 and 11 February. Mrs B agreed to a meeting on 25 February.

13. At the meeting on 25 February Mrs B's aunt said she wanted to return home as soon as possible. On 26 February the Council told Mrs B the assessment was for around 40 hours per week. Mrs B reluctantly accepted the 40 hours per week care package. Mrs B's aunt returned home on 28 February.

Analysis

14. I understand Mrs B's concern about the removal of overnight support for her aunt when both the 2013 assessment and March 2014 assessment referred to her as having critical needs for overnight care. The Council cannot explain why that is the case as the social worker who completed the 2014 assessment has now left the Council's employment. I do not consider that acceptable. The Council should have kept records to show the social worker's reasoning for not awarding overnight care in 2014. Failure to make clear in the assessment why overnight care had not been awarded is fault.

15. I am, however, satisfied the March 2014 assessment was reviewed in May 2014. That reviewing officer did not consider it necessary to award overnight care. As that review was completed within a short period of the March 2014 review I consider it unlikely the situation would have been significantly different in March 2014. So, while I understand Mrs B strongly disagrees with the Council's assessment that her aunt did not require overnight care in 2014 I cannot criticise the Council for reaching that view. That is because, as I said in paragraph 2, it is not my role to comment on the merits of the Council's decisions. The Council decided Mrs B's aunt did not qualify for overnight care in 2014 after carrying out a proper assessment. It is not my role to comment on the merits of that assessment, no matter how much Mrs B disagrees with it. I recommend though

the Council ensure care assessments record an officer's reasoning for not awarding support for something identified as a critical need in the assessment.

16. I understand why Mrs B would consider overnight care necessary given her aunt had a fall during the night in January 2015. I understand why Mrs B believes that would not have happened if her aunt's assessment had included provision for overnight care. However, I cannot speculate about that. The point is that even with the 2013 assessment Mrs B's aunt was not assessed as requiring support throughout the night every night. So, it is possible that even if the Council had awarded three nights overnight care this would not have prevented the fall in January 2015. I recognise Mrs B believes the Council should award significantly more hours care to her aunt, potentially covering seven nights per week. The Council does not agree with that assessment. As I have made clear, it is not my role to comment on the merits of that decision, particularly when it has been confirmed following a review.

17. In reaching that view I have taken into account Mrs B's contention that as her aunt was assessed as requiring overnight support on occasion in 2013 and again in 2015, the 2014 assessment was inaccurate. Mrs B says it is not consistent for the Council to award overnight support before 2014 and after 2014 but not during 2014 itself. I understand Mrs B's point. However, the difference between 2013 and 2014 is that the review assessment recorded Mrs B's aunt's son was providing overnight support. Taking that into account the reviewing officer concluded Mrs B's aunt did not require overnight support. Mrs B says her aunt only said she was receiving overnight support from her son because the Council had removed it from the assessment and she had no other option. However, that is not the reviewing officer's recollection of the discussion. The reviewing officer was clear she did not consider Mrs B's aunt required overnight support. I cannot reach a safe conclusion about the circumstances in which Mrs B's aunt said her son was providing overnight support given the differing recollections. However, as the reviewing officer was clear in her assessment Mrs B's aunt did not require overnight support there are no grounds for me to comment on that view. As I have made clear, it is not my role to comment on the reviewing officer's judgement. I therefore cannot criticise the Council for not awarding overnight support in 2014.

18. Mrs B says the Council refused to consider her appeal against the care plan completed in May 2014. Having considered the documentary evidence I note the Council reviewed that care plan and issued a new care plan on 3 June 2014. I am therefore satisfied the Council dealt with the request for an appeal. In reaching that view I am aware Mrs B asked for another review in 2015. The Council refused that request on the basis Mrs B's aunt had not requested a review when the Council issued the revised care plan in June 2014. I cannot criticise the Council for that decision. If Mrs B was dissatisfied with the care plan completed in June 2014 I would have expected her to request a review at that point. As the Council has pointed out, it cannot in any case assess someone based on retrospective needs.

19. The evidence I have seen satisfies me the Council placed Mrs B's aunt in a care home with her aunt's agreement. I say that because the notes from the discussions on the ward record Mrs B's aunt agreed to go into short term care. I therefore could not say the Council placed Mrs B's aunt in a care home against her will. Although Mrs B says her aunt did not know she was being discharged into a care home and thought she was being returned to her own home when she was discharged from hospital I am satisfied this was not the case. I say that because the documentary records show Mrs B's aunt signed the social worker's

letter which outlined the financial assessment that would take place to assess the contribution she would have to make towards her care costs in the care home. Documentation from another family member as well as Mrs B also confirms Mrs B's aunt understood she would go into short term care on discharge from hospital.

20. Mrs B says although there was a discussion about placing her aunt in a care home her aunt only agreed to go into one named care home. Mrs B says the Council therefore did not have her aunt's agreement to go into placement B as this was not her selected care home. Again, the documentary records do not support that. Instead, the documentary records show although Mrs B's aunt expressed a preference to remain in a specific area she said she would go anywhere if there were no beds available. Mrs B disputes the accuracy of the Council's records. However, the Ombudsman cannot take evidence on oath and normally relies on the documentary records. As the documentary records show Mrs B's aunt agreed to go into a care home and did not say she would only consider one home I have no grounds on which I could criticise the Council. It follows I cannot criticise the Council for charging Mrs B's aunt for the period she was in placement B.

21. In reaching that view, I recognise Mrs B's aunt asked to go home within days of arriving at the care home. Mrs B says her aunt was distressed at that point. I understand Mrs B's concern, particularly when she saw how upset her aunt was. However, as I have made clear, the documentary evidence shows Mrs B's aunt agreed to go into short term care. I am, however, satisfied the Council promptly began the process of assessing Mrs B's aunt's to arrange for her to return home once it became aware of her request. While there was a delay between 30 January, when the family asked for the arrangements to be made and 28 February when Mrs B's aunt returned home, I am satisfied that delay resulted from the need to make arrangements with the family to carry out an assessment. I cannot criticise the Council for that delay given it could not return Mrs B's aunt home without assessing her to ensure she was safe.

22. Mrs B says the Council placed her aunt in the care home and then closed the file. Mrs B points to that as evidence the Council intended her aunt to stay in the home permanently. I have found no evidence to support that conclusion. Instead, the documentary evidence shows the placement in the care home was for short term care for around six weeks. It may be family members understood the case had been closed because the Council referred to allocating it to a social worker to carry out an assessment to make the arrangements for a return home. However, that the case was not allocated to a social worker does not mean it had been closed. As I have seen no evidence to suggest the Council intended the stay to be anything other than short term care I have no grounds to criticise it.

23. Mrs B also says the Council knew her aunt did not have the mental capacity to make decisions for herself. Mrs B says this has been an ongoing situation from 2014 onwards. None of the documentary evidence refers to any suggestion, either from the professionals involved or family members, that Mrs B's aunt did not have capacity to agree to go into a care home in January 2015. Indeed, when the situation was discussed on the ward on 22 January 2015 with family members present the records show the social worker referred to Mrs B's aunt having capacity to make her own decision about where to go. If, as Mrs B says, the family had concerns about her aunt's capacity at that point I would have thought they would have raised that issue at the time. I have seen no evidence they did so. I therefore cannot criticise the Council for treating Mrs B's aunt as having capacity to make her own decisions.

Recommended action

24. I recommend the Council make sure care assessments explain the Council's reasoning when it decides not to make provision for needs which have been assessed as critical.

Final decision

25. I have completed my investigation and found fault in part of the complaint which caused injustice to Mrs B and her aunt. Although Mrs B does not agree with my decision I am satisfied the action the Council will take is sufficient to remedy that injustice.

Investigator's decision on behalf of the Ombudsman

11 May 2016

Complaint reference:
15 015 978

Complaint against:
Nottinghamshire County Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: The Council was at fault for taking too long to complete the Stage 2 investigation into Mr B's complaint. The Council has explained why there was a delay and apologised. There is no evidence to support the rest of Mr B's complaint.

The complaint

1. The complainant, whom I shall call Mr B, complains that:
   - The Council failed to properly consider his complaint about a social worker at Stages 2 and 3 of the children's social care complaints procedure.
   - The Council failed to properly consider his complaint about an Initial Child Protection Conference (ICPC) at Stages 2 and 3 of the children's social care complaints procedure.
   - The Stage 2 investigation into his complaint took too long causing confusion.
   - Council officers lied during the investigation.

The Ombudsman's role and powers

2. The Ombudsman investigates complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. She 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, she may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1))***

3. The Ombudsman cannot question whether a council's decision is right or wrong simply because the complainant disagrees with it. She must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, section 34(3))***

How I considered this complaint

4. I discussed the complaint with Mr B and considered all the information he provided. I also sent the Council enquiries and considered its responses. I gave the Council and Mr B the opportunity to consider my draft decision and considered their responses.

5. Some of the papers provided to me refer to Mr B and his wife as being unhappy with the Council's actions. For consistency my report names Mr B as the complainant.

6. During my investigation Mr B has provided extra information in support his complaint. I have considered this information as part of my investigation when I considered it appropriate to do so.

What I found

Legislation / Complaints procedure

7. The law sets out a three stage procedure for councils to follow when looking at complaints about children's social care services. At Stage 2 of this procedure the Council appoints an Investigating Officer (IO). They also appoint an Independent Person (IP) who is responsible for overseeing the investigation.

8. If a complainant is unhappy with the outcome of the Stage 2 investigation they can ask for a Stage 3 review.

9. If a council has investigated something under this procedure the Ombudsman would not normally re-investigate it. However, she may look at whether a council properly considered the findings and recommendations of the independent investigation.

Background

10. Mr B and his wife (Mrs B) have residency orders for two grandchildren. One is now aged eighteen (Child X) and the other is sixteen (Child Y). Child X is female and has learning difficulties. Child Y is male. Both have lived with Mr and Mrs B since 2002.

11. Mr B say that in July 2014 he and his wife asked social services for support with Child X. Mr and Mrs B had become concerned with Child X's behaviour and felt she was vulnerable to sexual exploitation.

12. Social Worker A had been working with Mr and Mrs B's family for over a year. Mr and Mrs B eventually became unhappy with Social Worker A as they say she did not provide the support asked for. They say that Social Worker A did not return their telephone calls and failed to attend meetings.

13. Mr B submitted a complaint to the Council about Social Worker A. On 20 October 2014 Mr B and his wife met with two council officers and their local councillor. One of the council officers is a Group Manager (Officer F). The other is a Service Manager (Officer G). At the meeting the Council agreed to change the family's social worker, to arrange some respite care for Child X and Child Y, and to arrange a befriending service for Child X.

14. Following the meeting Officer F wrote to Mr and Mrs B. Her letter confirmed their discussions and that an ICPC would take place on 05 November 2014.

15. ICPCs take place when the Council believe a child may continue to suffer or be at risk of suffering significant harm. Officer F's letter explained the ICPC would look at the issue of Child X being vulnerable to sexual exploitation and how this would be managed.

16. The Council invited Mr and Mrs B to a meeting on 05 November 2014. This was the ICPC mentioned in Officer F's letter. Mr and Mrs B say they thought the purpose of the meeting was to discuss their request for help. They say that they did not realise it was an ICPC.

17. Mr B says the Children's Social Care Department did not explain the child protection process or tell them why the meeting was taking place. They say they did not have time to read the ICPC reports before the meeting. This meant they

did not have time to object to the content of the report, prepare for the meeting, or have the opportunity to defend themselves. The result of the ICPC meeting was for Child X to be subject to a Child Protection Plan.

Stage 1 Complaint

18. On 24 December 2014 Mr B submitted a Stage 1 complaint to the Council. The main points of his complaint were as follows:

- That Social Worker A did not listen to requests for help with Child X. She had failed to return telephone calls and had not attended appointments.
- That Social Worker A did not implement the help agreed in the meeting held on 20 October 2014.
- That Social Worker A prepared a report for the ICPC meeting that was untrue.
- That Social Worker A did not give Mr and Mrs B time to consider the report before the ICPC meeting, nor did she explain what the meeting would be about.
- That Social Worker A chaired a Core Group meeting on 14 November 2014 and did not give Mr B the opportunity to speak.

19. On 24 December 2014 Officer G responded to Mr B's complaint. She apologised that Mr B did not have the opportunity to read the report before the ICPC, clarified the purpose of the ICPC and apologised if Mr B felt his opinion had not been sought. Officer G also apologised if Social Worker A had not returned Mr B's telephone calls.

20. On 05 January 2015 Mr B telephoned the Council as he was unhappy with Officer G's response. He reiterated his original complaint and provided what he believed were examples of "lies" written by Social Worker A in the report for the ICPC.

21. On 07 January 2015 Officer G responded to Mr B. She invited Mr B to write and explain why he disagreed with the report produced by Social Worker A for the ICPC. Officer G would then add this information to Child X's file. Officer G explained she could not confirm if Social Worker A had not responded to phone calls but apologised if this was the case.

22. On 22 January 2015 Mr B asked the Council to consider his complaint at Stage 2 of the children's social care complaints procedure.

Stage 2 Investigation

23. In response to Mr B's request the Council escalated his complaint to Stage 2 of the children's social care complaints procedure. Mr B confirmed on 30 March 2015 the scope of the investigation. There is no need for me to reproduce Mr B's complaint in full.

24. The Council appointed an IO and IP to carry out and oversee the investigation. During the investigation the original IO became unwell and the IP took over as she was familiar with the case. The Council then appointed a new IP. In July 2015 Officer H from the Council wrote to Mr and Mrs B to explain this and to apologise for the delay in completing the investigation.

25. In October 2015 the IO and IP completed their reports and sent copies to the Council. The IO did not uphold any of Mr B's complaints.

26. On 23 October 2015 Officer F wrote to Mr and Mrs B as the AO for the investigation and told them she supported the IO's findings. This completed Stage 2 of the children's social care complaints procedure.

Stage 3 Hearing

27. At the beginning of November 2015 Mr B told Officer H he would like to proceed to Stage 3 of the complaints procedure. Mr B supplied evidence before the hearing which took place on 08 December 2015.

28. The panel did not uphold Mr and Mrs B's complaint and concluded that: *"In the Panel's view [the IO] has conducted a thorough investigation and evidenced her findings which are supported by the Independent Person."*

29. On 07 January 2016 the Council wrote to Mr and Mrs B and confirmed it agreed with the Stage 2 and Stage 3 responses.

Was there fault by the Council?

30. Mr B's complaint to the Ombudsman relates to four main issues. I have addressed each of these below.

The Council failed to properly consider his complaint about a social worker (Social Worker A) at Stages 2 and 3 of the children's social care complaints procedure.

31. In support of his complaint Mr B has supplied me with a number of examples and I have carefully considered all of them.

32. In one example Mr B told me how on 04 August 2014 Officer I tried to contact Social Worker A by telephone. Officer I left two messages for Social Worker A. Mr B feels this shows Social Worker A was difficult to contact and the IO should have obtained Officer I's phone records. This could then have formed part of her report.

33. In another example Mr B told me about a number of occasions when he gave Officer I letters to pass on to Social Worker A. Mr B is unhappy Social Worker A did not respond and feels this issue was not properly addressed by the Stage 2 or Stage 3 responses to his complaint.

Analysis

34. I understand Mr B is unhappy the IO did not obtain Officer I's phone records as part of her investigation. But the IO's report deals extensively with the contact between Social Worker A and Mr B's family. This includes a table spanning three pages recording contact over a five month period. The phone records would simply have shown that Social Worker A did not answer her phone at a particular time. I do not consider the IO to be at fault for not obtaining Officer I's phone records.

35. Mr B is certain he gave Officer I letters to pass to Social Worker A. But the IO's decision on this matter is based on interviews with staff and the case records. Officer I said that while she did see one letter from a consultant she did not take it away from the family home. Officer I said Mr B did not give her other letters to pass to Social Worker A. The IO found there was no evidence to show Social Worker A received the letters in question and I do not find fault with how this decision was reached.

36. The IO's report into Mr B's complaint is extremely detailed. It sets out the background to Mr B's complaint, contains a chronology of key events and describes how the IO carried out the investigation. In carrying out her investigation the IO interviewed the people she considered most important to the complaint and considered information provided by Mr B. The IO also considered information available on Council systems such as case notes for Child X.

37. The IO's report addresses each of Mr B's complaints in turn. The process the IO followed to investigate each particular complaint is clear. For each complaint the IO sets out how she reached her decision. The IO clearly recorded her decision into each complaint.

38. GBC sets out the process councils should follow for Stage 3 hearings. I have considered the Stage 3 report and listened to some of the recording taken during the hearing. The process followed is in line with the one set out in GBC.

39. Mr B claims he did not have time to say everything he wanted and the IO spoke for too long. Mr B also claims the meeting came to an abrupt end as the IP had to leave.

40. Having listened to the recording of the meeting I consider that Mr B and Mrs B had sufficient opportunities to present their case and to ask questions. The recording confirms the hearing ended as the IP had to leave but it did last for three hours. The Chair also asked Mr and Mrs B at the end of the hearing if there was anything else they would like to add and they confirmed there was not.

41. While it is unfortunate the hearing ended the way it did I cannot say there was any significant fault in the administration of the Stage 3 hearing.

42. The Stage 3 report into Mr B's complaint is far less detailed than the one compiled by the IO. This is expected as the purpose of the panel is to review the Stage 2 report and to make recommendations it considers appropriate. I consider the report to be an accurate representation of the discussions held.

43. When I originally spoke to Mr B about his complaint I explained I would not be able to reinvestigate matters or to criticise the Stage 2 and 3 responses unless there was clear evidence of fault.

44. Having considered all the information available I do not consider the Council to be at fault in the way it considered Mr B's complaint at Stages 2 and 3 of the children's social care complaints procedure.

45. **The Council failed to properly consider his complaint about an ICPC at Stages 2 and 3 of the children's social care complaints procedure.**

46. Mr B's complaint about the ICPC was made under three main headings:

- The Council failed to explain the child protection process and to check Mr and Mrs B's understanding of the process.
- Mr B felt the report written by Social Worker A was based on incorrect information and Mr and Mrs B were not given the opportunity to read the report. Mr B also complained Social Worker A did not provide a copy of the ICPC minutes and failed to tell Mr and Mrs B about concerns over Child X's behaviour.
- That Social Worker A recommended Child Y be placed on a Child Protection Plan because of neglect by Mr and Mrs B.

Analysis

47. As this complaint was considered as part of the IO's wider Stage 2 investigation the comments I have already made apply. In considering each complaint the IO reached a decision on the evidence available.

48. For example, the IO identified a number of pieces of evidence where Mr and Mrs B were notified of the ICPC. Child X and Child Y had also previously been subject to Child Protection Plans. Based on this information the IO did not uphold Mr B's complaint the Council failed to explain the child protection process.

49. The Stage 3 response into these matters is less detailed but the panel supported the Stage 2 findings. The report documents the panel's discussions around the concerns raised by Mr B about the ICPC.

50. Whenever a decision is taken to convene an ICPC the needs of the child are the priority and take precedence over all other matters. While I fully understand the stress an ICPC can cause a child's carers I can find no evidence of fault in the Stage 2 and Stage 3 investigations into this matter.

61. **The Stage 2 investigation into his complaint took too long causing confusion.**

52. The Regulations for children's social care complaints allow twenty five days for a Stage 2 investigation. This can be extended to 65 days if the complainant is in agreement.

53. As set out in paragraph 31 the IO originally appointed to investigate Mr B's complaint became unwell. The IP then took over the investigation with a new IP appointed.

54. Due to the original IO becoming unwell there was a delay in completing the Stage 2 investigation. The Council has said it took 143 days to complete. This is fault and Officer H apologised for this in an email and letter dated 08 July 2015 and 23 July 2015 respectively. The Stage 3 panel also noted there had been a significant delay in completing the investigation.

Analysis

55. The Council was at fault due to the delay in carrying out the Stage 2 investigation. This caused Mr B injustice because of the upset and uncertainty he had to endure while waiting for the Stage 2 findings.

56. The Council has accepted there were delays in completing the investigation and has provided an explanation and an apology.

57. I consider the actions already taken by the Council to be a suitable remedy for the injustice caused.

58. **Council officers lied during the investigation.**

59. This complaint is a broad one which overlaps with many of the issues already considered.

60. Mr B is clearly unhappy with the information provided by certain council officers during the investigation and has provided examples he believes support his complaint.

61. I have already covered some of these issues above and they include:

- Officer I denying that Mr and Mrs B gave her letters to pass to Social Worker A.
- Social Worker A denying she received letters from Mr and Mrs B.
- That Social Worker A lied when she said Child X's behaviour prevented her from sharing her report with Mr and Mrs B on the eve of the ICPC.

Analysis

62. Mr B has provided examples where his interpretation of events is clearly different to those provided by council officers. But in situations where two parties disagree on what was said it is unlikely the Ombudsman would ever be able to find out exactly what happened.

63. While I understand how strongly Mr B feels about the issues he has raised I do not uphold his complaint that council officers lied during the investigation.

Final decision

64. I uphold Mr B's complaint the Council took too long to complete a Stage 2 investigation into his complaint. The Council's explanation and apology is an appropriate remedy. I do not uphold the rest of Mr B's complaint and have ended my investigation.

Investigator's final decision on behalf of the Ombudsman

3 May 2016

Complaint reference:
15 010 488

Complaint against:
Nottinghamshire County Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: The Council failed to document a safeguarding investigation properly. The documentation failed to record the specific concerns raised and to properly explain how it reached the decision that there was no neglect. The Council has agreed to apologise to Mr Y and provide further information about how the Council reached the safeguarding decision.

The complaint

1. The complainant, whom I refer to as Mr Y, complains about services provided to his late grandfather, whom I refer to as Mr S, at Jubilee Court. Mr Y complains that Nottinghamshire County Council failed to complete a retrospective safeguarding investigation properly.

The Ombudsman's role and powers

2. The Ombudsman investigates complaints of injustice caused by maladministration and service failure. I have used the word fault to refer to these. The Ombudsman cannot question whether a council's decision is right or wrong simply because the complainant disagrees with it. She must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, section 34(3))***

3. The Ombudsman investigates complaints about councils and certain other bodies. Where an individual, organisation or private company is providing services on behalf of a council, the Ombudsman can investigate complaints about the action of these providers. ***(Local Government Act 1974, section 25(7))***

4. If the Ombudsman is satisfied with a council's actions or proposed actions, she can complete her investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i))***

How I considered this complaint

5. I considered information from a previous decision related to this complaint (case reference 14014168) and information provided by Mr Y. I made enquiries of the Council and considered information it provided.

6. I considered inspection reports from the Care Quality Commission (CQC) who is the statutory regulator of care services. It keeps a register of care providers who show they meet the fundamental standards of care, inspects care services and issues reports on its findings, and has power to enforce its recommendations for improvement of registered services.

7. I considered the relevant legislation, government guidance and local policies in place at the time of the complaint.

8. I have written to Mr Y and the Council with my draft decision and given them an opportunity to comment.

What I found

Background information

9. Mr S went into Jubilee Court in October 2009. The Council funded and arranged the placement. The Council ran Jubilee Court but sold it in mid 2012. Mr Y complains that the care provided at Jubilee Court was inadequate, in particular that:-

- it failed to regularly carry out risk assessments and care plan reviews. When they were carried out, they remained unchanged, even though Mr S's needs were increasing;
- in June 2012 it stopped regular personal safety checks;
- it failed to properly monitor Mr S's weight loss and keep adequate nutrition and fluid charts;
- it failed to deal with other residents bullying Mr S and manage his risk of falling.

10. Mr S died in May 2013. Mr Y says he is concerned about the care Mr S received leading up to his death and that CQC had also already identified shortfalls in Jubilee Court's care.

11. The Ombudsman considered a previous complaint regarding this case. The outcome was that the Council agreed to complete a retrospective safeguarding investigation into the matters raised.

What happened

12. The Council completed a safeguarding investigation. The officer involved:-

- considered Jubilee Court's care records;
- considered the Council's records. A review completed by the Council on 22 February 2012 said that the family were happy with Jubilee Court.

13. The officer also contacted:-

- the GP who provided information about the end of life care for Mr S and commented that the family had said on 13, 14 and 15 May 2013 that they wanted Mr S to remain at Jubilee Court. Mr Y says that this information is inaccurate as the GP had already made the decision that Mr S should remain at Jubilee Court;
- a continuing health care colleague who explained that continuing care had completed a check list but found that Mr S did not have any nursing needs. Mr Y disputes this and says that the checklist was positive;
- contacted the coroner who reported no concerns;
- took account of CQC reports which in August 2013 identified that Jubilee Court needed to take action on a number of matters; one of these was the care and welfare of people who use the service. It said that there was no policy for the assessment and review of care; that the care provider had not reviewed risk assessments and failed to properly record food and fluid intake.

14. The officer found that although there were care plans and risk assessments in place there were no regular reviews. She also documented that there were no records to show that care staff had completed 30 minute/hourly observations, food and fluid charts or that there were repositioning charts in place for Mr S.

15. The officer however concludes that although there were gaps in the documentation there was no evidence to suggest that there were concerns about the care and support Jubilee Court provided.

What should have happened

16. A council must make necessary enquiries if it has reason to think a person may be at risk of abuse or neglect and has needs for care and support which mean he or she cannot protect himself or herself. It must also decide whether it or another person or agency should take any action to protect the person from abuse or risk. ***(section 42, Care Act 2014)***

Was there fault causing injustice?

17. The safeguarding completed in this case was unusual as it was retrospective and the person affected had died. While taking this into account I do not consider that the conclusions reached by the Council are sound. This is because the officer involved highlights inconsistencies within the care provider's recording but does not say why she considered that despite these inconsistencies there was no neglect. I consider this is fault.

18. In addition the safeguarding investigation did not record Mr Y's specific concerns and address all the individual points. If the Council did not consider it appropriate to investigate all the matters it should have recorded this as part of the investigation. I consider this is fault.

19. As a result of the faults I have identified I consider that Mr Y has the uncertainty of not knowing whether the decision reached by the Council is correct. I also consider that contacting Mr Y at the start of the process would have been good practice.

20. In response to a draft decision of this complaint the Council provided a further explanation of how it reached the safeguarding decision. I have considered the additional information and consider that it satisfactorily addresses the anomalies that it identified. As stated in paragraph 2, the Ombudsman does not usually challenge a professional judgement unless there is procedural fault. I am therefore unable to say that the outcome of the investigation is wrong.

Agreed action

21. I consider that Mr Y has suffered injustice as a result of the Council's failure to properly document its decision about why it felt there was no neglect. The Council has already sent an explanation about how the Council reached the safeguarding decision in particular how it decided that there was no neglect despite the omissions that it found and about how it considered all the elements of Mr Y's concerns outlined in paragraph 9. It has also agreed to:-

- within one month of the final decision apologise to Mr Y about the failure to properly evidence how the Council reached the safeguarding decision;
- within two months of the final decision to tell CQC about the safeguarding investigation and the outcome of the safeguarding including the explanation requested above;

- within two months of the final decision to remind staff about the importance of documenting how safeguarding decisions are reached.

Final decision

22. I uphold the complaint that the Council failed to properly record how it reached the safeguarding conclusions. This has caused Mr Y uncertainty. I consider the agreed actions are suitable to remedy the complaint and have completed my investigation and closed the complaint on this basis.

Investigator's decision on behalf of the Ombudsman