25 June 2019

Complaint reference:
19 002 640

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman will not investigate this complaint about an uneven road surface causing damage to the complainant's cycling equipment. This is because it is reasonable to expect the complainant to take court action if he thinks the Council is liable for the damage.

The complaint

1. The complainant, whom I refer to as Mr B, says the Council should pay for the damage caused to his cycling equipment by a strip of sunken and defective tarmac in the road.

The Ombudsman's role and powers

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

3. The law says we cannot normally investigate a complaint when someone could take the matter to court. However, we may decide to investigate if we consider it would be unreasonable to expect the person to go to court. ***(Local Government Act 1974, section 26(6)(c), as amended)***

How I considered this complaint

4. I have considered:

- Mr B's statement of complaint to the Ombudsman;
- The 10 May 2019 letter from the Council's Claims Team to Mr B; and,
- The comments and supporting documents submitted in response to a draft version of this statement.

What I found

5. The role of the Ombudsman is to consider complaints about administrative fault. We cannot establish negligence and liability in complaints involving damage to property. Adjudication on such matters usually involves making decisions on contested questions of fact and law which require the more stringent and structured procedures of civil litigation for their proper determination.

6. Claims for damage to property are therefore a matter for the Council's insurers and then, ultimately, for the courts.

7. The Council's insurers rejected a claim by Mr B, so it is now open to him to pursue the matter further in court if he thinks the Council has failed to properly

maintain the road for cyclists. I consider it reasonable for him to do so, because only the courts can decide if the Council has been negligent and is liable for the damage. In addition, only the courts can decide what compensation/damages must be paid; the Ombudsman has no powers to enforce such a remedy.

Final decision

8. The Ombudsman will not investigate Mr B's complaint. This is because it is reasonable to expect him to pursue a court remedy if he thinks the Council should pay for the damage to his property.

Investigator's decision on behalf of the Ombudsman

5 July 2019

Complaint reference:
19 001 345

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman will not investigate this complaint relating to the deeds of the complainant's property. The complainant was aware of the matter in October 2016 and it is now too late for him to complain to the Ombudsman.

The complaint

1. The complainant, who I refer to here as Mr B, has complained about a plan included with the deeds of his property. He says the Council's records are inaccurate and it should change them so they accord with those held by HM Land Registry.

The Ombudsman's role and powers

2. The Local Government Act 1974 sets out our powers but also imposes restrictions on what we can investigate. It says we cannot investigate late complaints unless we decide there are good reasons. Late complaints are when someone takes more than 12 months to complain to us about something a council has done. ***(Local Government Act 1974, sections 26B and 34D, as amended)***

3. We provide a free service but must use public money carefully. It is not a good use of public resources to investigate complaints about complaint procedures, if we are unable to deal with the substantive issue. ***(Local Government Act 1974, section 24A(6), as amended)***

How I considered this complaint

4. I have considered what Mr B said in his complaint. I have also considered our records on previous complaints he has made to us. Mr B commented on a draft before I made this decision.

What I found

5. Mr B complained to us in January and August 2018 about matters relating to rights of way on a footpath. These were not the same complaint as the one he has made now.

6. Mr B stated in this complaint that he has attempted to resolve the matter with the Council since October 2016. He complained to us in April 2019 and was clearly aware of the issues more than 12 months before he did so. Given he had made two complaints to us in the intervening period, I see no exceptional reason the restriction on our jurisdiction I describe in paragraph 2 should not apply.

Final decision

7. I have decided we cannot investigate this complaint because it is made too late. We will investigate how the Council has dealt with Mr B's complaint as this would not be a good use of public funds.

Investigator's decision on behalf of the Ombudsman

09 July 2019

Complaint reference:
19 003 208

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman will not investigate Ms X's complaint the Council issued her with penalty charge notices for her children's non-attendance at school. This is because we cannot achieve the outcome she wants, and the court is the appropriate body to consider the Council's decision.

The complaint

1. The complainant, whom I shall call Ms X, complains the Council issued her with penalty charge notices for her children's non-attendance at school. Ms X says there were good reasons she took her children out of school. Ms X is also unhappy that Headteachers can decide not to approve absence during term-time, and then ask the Council to issue a penalty charge notice.

The Ombudsman's role and powers

2. We have the power to start or discontinue an investigation into a complaint within our jurisdiction. We may decide not to start or continue with an investigation if we think the issues could reasonably be, or have been, raised within a court of law. (***Local Government Act 1974, sections 24A(6) and 34B(8), as amended)***

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

How I considered this complaint

4. I considered Ms X's complaint to the Ombudsman and the information she provided. I also gave Ms X the opportunity to comment on a draft statement before reaching a final decision on her complaint.

What I found

5. The procedure for a Council to enforce against non-attendance at school is for it to issue a penalty notice. If a parent accepts the penalty and pays it, the Council need take no further action. If the parent disputes the penalty by not paying it, the Council must prosecute the offence in the magistrates' court. Only the Court can consider any evidence put forward in defence and then decide whether the parent committed the offence. The Ombudsman can do neither. ***(Education Act 1996, sections 444 and 444A)***

6. If Ms X believes the penalty charges are not justified, or have not been correctly issued, and the Council pursues a prosecution, she can put forward an argument

in court. There is no dispute over whether Ms X took her children out of school. But there is dispute about the merits of the decision to issue a penalty charge. The court is in the best place to decide the merits of the opposing arguments, as the law provides.

7. Also, the Ombudsman has no powers to consider whether a Headteacher was right to refuse to authorise a child's absence. This is because we have no powers to consider complaints about the internal management of schools. An investigation by the Ombudsman is not therefore appropriate.

8. Ms X is also unhappy with the Council's process for administering penalty charges and would like it reviewed. The process on the Council's website explains that only Headteachers can decide to authorise absence during term-time. Schools have powers to issue penalty charges, but the Council issues them on their behalf.

9. Ms X believes Headteachers will not always make decisions in a child's best interests, and that the Council should make an "independent judgment" about whether to issue a fine. In her complaint to the Ombudsman, Ms X referred to the different systems other councils operate. But the role of the Ombudsman is to look for fault causing injustice. It is not our role to say how councils should operate. These are decisions for council officers and elected members. We cannot therefore achieve the outcome Ms X wants.

10. Ms X has complained to the Council but is not happy with how it has dealt with her complaint. The Ombudsman will not normally investigate a council's complaint handling if we are not going to look at the substantive issue complained about. This applies here.

Final decision

11. The Ombudsman will not investigate Ms X's complaint. This is because we cannot achieve the outcome she wants, and Ms X can challenge the Council's decision in court.

Investigator's decision on behalf of the Ombudsman

11 July 2019

Complaint reference:
19 003 420

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman cannot investigate this complaint about the execution of a search warrant by the Council at the complainant's home. This is because the matter is connected to court proceedings.

The complaint

1. Mr X says the Council executed a search warrant on his property for a business that has nothing to do with him. He says the business relates to a previous tenant who moved out 5 years ago. Mr X believes the Council should not have done this and should have been aware the business it had a search warrant for no longer trades at his address.

The Ombudsman's role and powers

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

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

How I considered this complaint

4. I considered the information provided by Mr X. He comment on the draft version of this decision.

What I found

5. The Council says it has information that evidence connected to a current trading standards investigation may be stored at Mr X's address.

6. It says it presented the evidence to the magistrates' court when it requested a search warrant. The court granted the Council a warrant to enter and search Mr X's home. This was then executed in the presence of police officers.

Final decision

7. I cannot investigate this complaint. This is because the information used by the Council to get the search warrant was considered by the magistrates' court as part of criminal proceedings before a court of law. Therefore, the restriction I describe in paragraph 3 applies and we have no jurisdiction to investigate this complaint.

Investigator's decision on behalf of the Ombudsman

15 July 2019

Complaint reference:
18 016 189

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Ms X complains about how the Council handled safeguarding referrals about her children, and the Child in Need process. She complains the Council has not properly responded to her complaint. She says this has caused her distress. The Ombudsman does not find fault with the Council.

The complaint

1. The complainant, who I refer to here as Ms X, complains that:

a) her children's paternal grandmother, who has not been involved with the family for 18 years, was invited to a Child in Need meeting;

b) the Child in Need plan had nothing to do with the children;

c) the Child in Need process was not handled properly and should never have started;

d) the Council said Ms X said her son is her full-time carer, which she disputes;

e) the children's paternal grandmother makes malicious safeguarding referrals, which the Council could deal with better; and,

f) the Council has not properly responded to her complaint.

2. Ms X says this has caused her distress.

The Ombudsman's role and powers

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

How I considered this complaint

4. I considered the information and documents provided by Ms X and the Council. I spoke to Ms X about her complaint. Ms X and the Council had an opportunity to comment on an earlier draft of this statement. I considered all comments before I reached a final decision.

5. I have considered the relevant statutory guidance and policies, set out below.

What I found

Guidance and policies

Safeguarding referrals and the Child in Need process

6. The government publishes guidance on safeguarding children and promoting children's welfare, 'Working Together to Safeguard Children' (regularly updated). This outlines the specific duties of different agencies working with children and families.

7. The guidance stresses the importance of timeliness and sets out timescales that actions should be completed within. It says within one day of receiving a referral, a local authority should make a decision about the next steps and what kind of response is needed. This includes determining if the child needs immediate protection, if urgent action is needed, if the child is in need, and if there is reasonable cause to suspect the child is suffering, or is likely to suffer, significant harm.

8. Once a decision has been made on what action is needed, the guidance says this should be followed by an assessment. Assessments should determine if the child is in need, what kind of services the child needs, and if specialist assessments are needed to help the local authority's decision-making. The assessment should take no more than 45 days to complete.

9. After this, the social worker should agree the next steps with the family and other professionals. This could be to agree a Child in Need plan or a Child Protection Plan. The social worker coordinates the provision of appropriate services.

10. The next stage is to review the plan and the outcomes for the child. This could be referring the child for non-statutory services, a referral for more in-depth enquiries, or to close the case.

11. If the plan is a Child in Need plan, the first review should be held within three months of the start of the plan. Further reviews should take place at least every six months after that.

12. The Council publishes its safeguarding procedures on its website. This says that a Child in Need planning meeting must be convened within ten working days. It says that the social worker should agree with the family who should be invited from their family to attend the meeting.

13. The Council's safeguarding policy says Child in Need plans should be based on the identified needs of the child, and be focussed on the outcomes.

Complaints procedure

14. The Council's complaints procedure says it will respond to complaints within 20 working days, in most cases. If the complainant is not happy with the Council's response, they can discuss the next steps with the complaints team.

15. The procedure says that if a complainant remains dissatisfied once a complaint has completed the process, they can contact the Ombudsman.

What happened

16. Ms X and her late-husband, Mr Y, have two children: M who is 17, and F who is seven. Ms X and Mr Y were separated.

17. In February 2018, the Council received a referral about possible concerns for M and F. The Council decided to do an assessment. This was allocated to the assessment team the day after the referral was received.

18. In March, the Council completed its assessment. Shortly after this, it held a Child in Need meeting. Both parents were invited to attend. Mr Y was not able to attend, so his mother (Mrs L) attended the meeting on his behalf.

19. The meeting was held in two halves, with Ms X in the first half, and Mrs L in the second half.

20. In April, the Council held a Child in Need review meeting where the Child in Need plan was ended.

21. In December, Ms X complained to the Council. She said the Council lied about M being a full-time carer. She said the Council did not tell her Mrs L would be at the Child in Need meeting in March. She said she was unhappy with how the Council had treated her.

22. In January 2019, the Council responded to Ms X's complaint. It said Mr Y had asked the Council that his mother, Mrs L, attend the Child in Need meeting on his behalf.

23. The Council said the meeting was held in two halves, with Ms X attending the first half of the meeting, and Mrs L attending the second half.

24. The Council said there had been an anonymous referral in November 2018 which the Council assessed. It said it closed the case with no further action because there was no evidence of harm. The Council said it has a duty to explore the concerns raised regardless of where or who the referral comes from.

25. Ms X called the Council and spoke to a complaints officer. The Council followed this up in writing. It said it could not investigate an allegation Ms X made about Mrs L stealing from her. The Council signposted Ms X to the Ombudsman.

Analysis

Mrs L at the Child in Need meeting

26. Ms X complains that Mrs L, who has not been involved with the family for 18 years, was invited to the Child in Need meeting in March 2018 (part a of the complaint).

27. The Council's complaint response said Mr Y had the right to ask someone to attend the meeting on his behalf. The Council said it was aware that Ms X had raised concerns about Mrs L before which is why the meeting was held in two halves. It said Mrs L was not in the meeting with Ms X.

28. Ms X acknowledges that Mr Y asked for Mrs L to attend on his behalf. Ms X says the Council did not tell her Mrs L would be there.

29. The Council says initially the social worker had agreed with Mr Y that she would visit him after the meeting and share the outcome with him, because he was too ill to attend. It says that on the day of the meeting Mr Y contacted the Council and asked that Mrs L attend the meeting on his behalf. The Council says it respected this request.

30. The Council says that Ms X only asked that she did not sit in the same room as Mrs L. It says Ms X did not tell the social worker she did not want Mrs L there at all.

31. The Council's procedure says social workers should agree with the family which family members should be invited to the meeting. Up until the day of the meeting, the Council complied with this.

32. Mr Y had a right to ask the Council for Mrs L to attend the meeting on his behalf. The Council respected this wish. Mr Y told the Council on the day of the meeting that he wanted Mrs L to attend.

33. It is my view that there was insufficient opportunity for the Council to have told Ms X in advance that the plans had changed, and Mrs L would be attending on Mr Y's behalf. For this reason, I do not find fault with the Council.

34. The Council allowed Mrs L to attend on Mr Y's behalf, and it allowed the meeting to be held in two halves so that Ms X did not have to sit in the same room as Mrs L. For this reason, I find that the Council acted appropriately and respected the wishes of both parents. Because of this, I do not find the Council at fault.

Child in Need plan

35. Ms X complains that the Child in Need plan had nothing to do with the children (part b of the complaint).

36. Ms X says all the Child in Need plan had in it was for her and her children to attend bereavement counselling. This was to prepare for when Mr Y passed away.

37. Ms X says that she was not told that M and F would be referred for counselling for children with substance misusing parents. She says she stopped misusing alcohol in October 2017. She says M got a phone call from a counsellor 'out of the blue' and was upset by it.

38. The minutes of the Child in Need meeting say that Ms X said the only support she and the children needed was counselling.

39. The Child in Need plan includes access for counselling for M and F, social worker to visit both children and complete direct work with them every four to six weeks, to monitor Ms X's alcohol misuse, and for both parents to identify family members to support Ms X and the children, including providing care for the children.

40. I find that the main and central focus of the Child in Need plan was the children's wellbeing, as it should have been, in line with the guidance and the Council's own policy. The plan gave specific outcomes that relate to the identified risks and needs. I find that it was an entirely appropriate plan.

41. The plan says that the children will be referred for counselling. It does not specify which agency or organisation would provide the counselling. I find that the Council acted in line with the Child in Need plan, and referred the children to a service that could provide the support the children needed. For this reason, I do not find the Council at fault.

42. It is unfortunate that M was upset by the phone call. However, this is not evidence of fault by the Council.

Child in Need process

43. Ms X complains that the Child in Need process was not handled properly and should never have started (part c of the complaint).

44. Ms X thinks that the children were put on the Child in Need plan because Mr Y raised concerns about her alcohol misuse. She does not understand why the children were put on the plan.

45. The Council says there has been a long history of referrals due to Ms X's alcohol misuse and allegations of domestic violence between Ms X and Mr Y. It says the safeguarding concerns at the time the children were put on the plan were to do

with how Ms X would support M and F when Mr Y (who was seen as a protective factor) passed away.

46. The Council says there were also concerns about M providing some of F's basic care when Ms Y was at work every weekday evening.

47. The Council received the referral, completed an assessment, placed the children on a Child in Need plan, and then removed the children from the plan at the first review meeting. It did so because there was no evidence of Ms X misusing alcohol. It found the children were coping well, and Ms X and the children had access to specialist support services. For this reason, it identified no further need for social care involvement.

48. I find that the Council followed the process within the timescales and in line with the guidance. I also find it acted in line with its own policy. There were no delays in the process. I find that the Council acted appropriately and proportionately. It did not keep the children on the plan for longer than necessary, and did not remove them from the plan earlier than necessary.

49. For these reasons, I do not find the Council at fault.

Full-time carer

50. Ms X complains that the Council said she had said M is her full-time carer, which she disputes (part d of the complaint).

51. Ms X says she has never needed a carer, and M has never cared for her.

52. The Council says concerns were raised about M caring for F, rather than for Ms X. It confirms that it has no records that say M was caring for Ms X.

53. I find no evidence that the Council said Ms X said M was her full-time carer. For this reason, I do not find fault with the Council.

Malicious safeguarding referrals

54. Ms X complains that Mrs L makes malicious safeguarding referrals, which the Council could deal with better (part e of the complaint).

55. She says she has called the police about this. She says the police are writing to Mrs L to tell her to stop harassing Ms X. Ms X says Mrs L has not made any referrals to the Council since December 2018. Ms X says the Council should not 'jump on' these referrals.

56. The Council has a duty to investigate all safeguarding referrals, regardless of where or who they come from. I do not find the Council at fault for exploring or investigating each referral it receives.

Complaint response

57. Ms X complains that the Council has not properly responded to her complaint (part f of the complaint).

58. Ms X says the Council 'skirted around' the issues she complained about, and did not give her proper answers. She is frustrated the Council did not answer her questions.

59. I cannot find any evidence of unanswered questions. Ms X is not able to give me any examples of questions that remain unanswered.

60. The Council's response to her complaint explained its decision and actions.

61. Ms X did not ask the Council to deal with her complaint at the next stage of its complaints procedure. The Council decided not to deal with Ms X's complaint at

the next stage. It says it was unclear how escalating the complaint would help Ms X because it was unlikely to have a different outcome.

62. The Ombudsman agreed that this was an appropriate course of action in this case.

63. The Council's complaints procedure says if a complainant is not happy with the complaints response, they can discuss the next steps with the complaints team. This is what happened.

64. I find the Council acted in line with its procedure. For this reason, I do not find fault with the Council.

Final decision

65. I have completed my investigation. I do not uphold Ms X's complaint because I have found no evidence of fault in the Council's actions.

Investigator's decision on behalf of the Ombudsman

19 July 2019

Complaint reference:
19 002 957

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman cannot investigate this complaint about the involvement of the Council's social services with the complainant's family. This is because the actions complained of were for the courts to consider and are out of our jurisdiction.

The complaint

1. The complainant, who I refer to here as Mrs J, says that the Council's social services have treated her unfairly and with bias, and have not provided her with the support that she needed to care for her children.

The Ombudsman's role and powers

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

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

How I considered this complaint

4. I considered the information provided by Mrs J and by the Council. I have also sent Mrs J an initial view for her comments.

What I found

5. Mrs J has 4 children. She complains that officers from the Council's social services have acted unfairly and with bias towards her. She feels that she was not provided with the support that she needed, and as a result, has lost care of her children.

6. Three of her children are now placed with their father, under a Child Arrangement Order imposed by a court in 2017.

7. The youngest child has been placed with their grandmother under a Special Guardianship Order imposed by a court in 2018.

8. It was for the court to consider the action of the Council's social services when making these orders. The complaint is therefore out of our jurisdiction.

Final decision

9. I cannot investigate the complaint, as it is out of jurisdiction. The LGSCO may not consider actions which could or should have been considered as part of court proceedings.

Investigator's final decision on behalf of the Ombudsman

24 July 2019

Complaint reference:
LGSCO: 17 017 711
PHSO: C2046588

Complaint against:
Nottinghamshire County Council
Church Street Medical Centre
The Moorlands Nursing Home

Local Government & Social Care OMBUDSMAN

Parliamentary and Health Service Ombudsman

The Ombudsmen's decision

Summary: Ms P complained that a care home and GP practice failed to properly respond to her father Mr D's ill health, which put him at unnecessary risk. On another occasion, a nurse at the care home failed to call an ambulance in time, reducing his chance of surviving the infection he died of. Further, that a council failed to carry out safeguarding investigations adequately. The Ombudsmen find some fault with the response of the GP practice and care home in the first incident, which caused Ms P distress. In the second incident the nurse failed to call an ambulance in time which reduced Mr D's chance of surviving. The Ombudsmen recommend action to address this. They find no fault with the safeguarding investigations.

The complaint

1. Ms P complained about Moorlands Care Home (the Home), which is run by Regal Care Trading Ltd., Church Street Medical Centre (the Practice), and Nottinghamshire County Council (the Council). She said:

a) In April 2017, the Home took too long to seek medical attention for her father Mr D, which caused a delay in his admission to hospital for treatment. This put Mr D at risk, and caused his condition to become life threatening. It caused significant distress to her.

b) A GP at the Practice did not review her father face to face, which contributed to the delay in his admission to hospital. The GP refused to discuss this with Ms P after she went to the surgery later that day.

c) The Council's safeguarding investigation into this incident was biased, did not allow her to have enough input, and did not identify the failings in care.

d) In August 2017, the Home again took too long to seek medical attention for Mr D, and a nurse did not call an ambulance despite being advised to by the 111 service because of suspected sepsis. This prevented Mr D from having the best opportunity to survive.

e) The Council's safeguarding investigation into this did not adequately consider the role of the nurse at the Home the day before Mr D's hospital admission.

f) In mid-June 2017, Mr D developed bowel problems but the Home failed to send a stool sample to the Practice for testing.

g) Ms P is unhappy with the way her complaint was handled. In particular, she did not receive an adequate response to her complaint about the Home's actions, and the response she received was significantly delayed.

2. Ms P says these events caused her significant stress, distress, and caused her ill health to worsen. She seeks better explanations about what happened, an acknowledgement of what went wrong, apologies, and changes to practice and procedures.

Parts of the complaint I investigated

3. I investigated all the complaint except part f. I have explained why at the end of this statement.

The Ombudsmen's role and powers

4. The Ombudsmen investigate complaints about 'maladministration' and 'service failure'. We use the word 'fault' to refer to these. If there has been fault, the Ombudsmen consider whether it has caused injustice or hardship ***(Health Service Commissioners Act 1993, section 3(1) and Local Government Act 1974, sections 26(1) and 26A(1)).*** If it has, they may suggest a remedy. Recommendations might include asking the organisation to apologise or to pay a financial remedy, for example, for inconvenience or worry caused. We might also recommend the organisation takes action to stop the same mistakes happening again.

5. We investigate complaints about councils and certain other bodies. Where an individual, organisation or private company is providing services on behalf of a council, we can investigate complaints about the actions of these providers. ***(Local Government Act 1974, section 25(7), as amended)***

6. The Ombudsmen have the power to jointly consider complaints about health and social care. Since April 2015, these complaints have been considered by a single team acting for both Ombudsmen. ***(Local Government Act 1974, section 33ZA, and Health Service Commissioners Act 1993, section 18ZA)***

7. We normally name care homes in our decision statements. However, we will not do so if we think someone could be identified from the name of the care home. ***(Local Government Act 1974, section 34H(8), as amended)***

8. The Ombudsmen cannot question whether an organisation's decision is right or wrong simply because the complainant disagrees with it. We must consider whether there was fault in the way the decision was reached. (***Local Government Act 1974, section 34(3), as amended, and Health Service Commissioners Act 1993, sections 3(4)- 3(7))***

9. If the Ombudsmen are satisfied with the actions or proposed actions of the bodies that are the subject of the complaint, they can complete their investigation and issue a decision statement. ***(Health Service Commissioners Act 1993, section 18ZA and Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

10. I considered information provided by the parties to the complaint, including relevant health and social care records from the Home, the Practice, the hospital to which Mr D was admitted, the 111 service, the out of hours GP service, and the ambulance service. I took account of relevant policy, law and guidance. I took clinical advice from an experienced GP, and a senior nurse with expertise in the care of older people.

11. I shared a draft of this decision with the parties to the complaint and considered their comments.

What I found

Legal and administrative context

Safeguarding

12. The safeguarding responsibilities of local authorities and their partners are set out in the Care Act 2014 and the accompanying statutory guidance. Section 42 of the Care Act 2014 says that 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.

Fundamental Standards of Care

13. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out the fundamental standards those registered to provide care services must achieve. The Care Quality Commission (CQC) has issued guidance on how to meet the fundamental standards which care must never fall below.

14. Regulation 12 says care must be delivered safely. Providers must minimise risks to a person as much as reasonably practicable. People providing care must have the appropriate skills.

The Code for Nurses and Midwives

15. The Nursing and Midwifery (NMC) issued *The Code* in 2009 (updated 2015). This sets out standards of conduct, performance and ethics for nurses and midwives. It says clear and accurate records should be kept of discussions, assessments, treatment and medicines given, along with how effective these have been. Nurses and midwives must "accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care". They must promptly refer a person to another practitioner when necessary for care or treatment.

Background

16. Mr D lived in a nursing home (the Home). He had a range of health problems, including swallowing difficulties, weakness on one side of his body, and confusion.

17. In the evening of 25 April 2017, Mr D was admitted to hospital with aspiration pneumonia (a chest infection caused by inhaling something rather than swallowing it) and hypoactive delirium (a condition where a person who is unwell becomes unusually sleepy and withdrawn). Ms P complained to the Council that the carers at the Home had not sought medical attention for him soon enough. The Council investigated under the safeguarding process but concluded that Ms P's concerns were not substantiated.

18. In the morning of 20 August 2017, Mr D was admitted to hospital after becoming unwell overnight. He sadly died on 25 August.

Complaint about the events of April 2017

19. Ms P said:

- She went to the Home in the late morning of 25 April because the GP said they would visit to review Mr D's medication at lunchtime. However, the GP did not come to Mr D's room, and Ms P found out in the early afternoon that the GP had left.
- When she entered Mr D's room, she found him not alert, with noisy, gurgling, breathing and unable to eat or drink. Two carers told her they'd heard a problem with his breathing, and also told the Home's senior care worker (the Senior Carer) this. However, the Home did not act on this, and the nurse did not see that he was unwell.
- Ms P said she spoke with the Senior Carer about Mr D's breathing, who said she would contact the Practice for a home visit. Then Ms P went to the Practice to express concerns about Mr D. The Practice receptionist said the GP was busy so they took Ms P's details, but no one called her back.
- The Home did not seek medical attention for Mr D until that evening, when he was very poorly. This delay meant Mr D's condition became life threatening.
- When the Home called out of hours health services, it gave incorrect information about Mr D. It said he'd only had breathing difficulties for the last twenty minutes, disregarding the problems earlier that day. This made it harder for the out of hours service to diagnose the problem.
- When she phoned the Home around 16:00 that day, the Senior Carer said she was waiting for the doctor to get back to her, but the Practice said this was not correct.
- The safeguarding investigation did not take into account that: the Senior Carer's statement said Mr D had been struggling to breathe, which she did not tell the out of hours medical service; no one called the GP when Mr D was seen to struggle to breathe in the afternoon; the Home did not tell the out of hours services that Mr D had a history of chest infections; and parts of the Senior Carer's statement were inaccurate.
- The social worker who completed the safeguarding investigation did not take proper account of the information from Ms P, and clearly believed the Home.
- The social worker told Ms P she would organise a meeting at the Home to discuss Ms P's concerns, but the social worker did not do this.
- If the safeguarding investigation into the April events had been upheld, the events of August may have been avoided.

The records

20. The Home's records of 25 April say Mr D ate all his breakfast, and drank fluids that morning. Staff provided personal care in the morning and had no concerns about him.

21. The Practice's records show that a receptionist sent a message to the GP at 15:09 to say Ms P attended and said she had sat in Mr D's room for three hours waiting for the GP. Ms P said two carers noticed that morning that Mr D was wheezing, and asked whether the GP knew this, since the carers did not tell the nurse on duty (Nurse B). The GP replied to the receptionist at 15:31 to say the carers had not mentioned Mr D wheezing or said he needed to be seen. She asked the receptionist to check with the Home whether he needed a visit.

22. At 15:27, the Senior Carer recorded that after the GP left Ms P said Mr D sounded chesty and wheezy, so she would phone the GP if they saw any further

wheeziness. Carers noted at 15:30 that Mr D drank coffee and ate most of a snack. At 17:16, carers recorded that Mr D ate most of his evening meal and drank all his drink.

23. At 18:38, carers recorded that they provided personal care to Mr D and his breathing seemed strained and he was in pain. They told Nurse B and the Senior Carer.

24. Nurse B told the 111 service at 18:46 that care staff had just reported that Mr D was very chesty and wheezy, but he had been fine that day. She had just been to see Mr D, and he was chesty and wheezy.

25. The out of hours service recorded that Nurse B said she had seen Mr D a few times that day, and neither she nor the care staff had noticed any problems. He had been eating and drinking. Now, he was chesty and wheezy and had a cough. The Senior Carer took over the call. She said Mr D had had breathing problems in the past. Earlier that day Ms P said Mr D was very chesty and she wanted him to see the GP, but the GP had left. The Home's staff had seen him since, and he was "not too bad", but he now sounded "quite bad" and did not look comfortable. The out of hours doctor said it sounded like the start of a chest infection and they would visit within two hours.

26. Before the out of hours doctor arrived, the Home called an ambulance for Mr D. The out of hours doctor visited at 20:07. They recorded that Mr D became "very chesty" that evening, with a raised temperature of 39. He ate dinner about 17:00 that day, with no coughing or choking. The doctor felt he probably had aspiration pneumonia. While the doctor was present, the ambulance arrived to take Mr D to hospital.

27. The hospital records show that Mr D was diagnosed with aspiration pneumonia and hypoactive delirium. A doctor recorded that his prognosis was uncertain. He could "take a turn for the worse".

28. At 09:35 on 26 April the Practice's receptionist messaged the GP to say they had checked with the Home whether Mr D needed a visit, and the staff from the Home said they would let the Practice know when they had spoken with the Senior Carer.

29. The Council's records, following discussion with the Home, say Ms P's concerns were resolved by the meeting with the GP and the Home on 12 May.

30. A social worker called the Home on 24 May. The Home said Mr D was usually wheezy. Staff on duty on 25 April did not consider that he was more wheezy than normal until later in the day. The Home said it told Ms P when they met that if she had concerns about Mr D that morning she should have told the nurse in charge.

31. The social worker decided that since Ms P had met with the Home to discuss her concerns and the issue may have been "lack of communication" between Ms P and the Home, the matter did not need a safeguarding investigation.

32. Ms P contacted the Council again in early June. She said she was not satisfied with the meeting in May. She was not happy that the Home told the out of hours services Mr D did not have a history of chest infections, when he did. It did not say that carers saw Mr D struggling to breathe. She said the Home should have called the GP sooner, and that if the Home gave the correct information to the out of hours services they would have called an ambulance straight away. The Council decided it would conduct a safeguarding enquiry.

33. The social worker visited the Home on 9 June. They reviewed Mr D's care plan, care logs, statements from staff, and spoke with the Home's manager and Nurse B. Nurse B wrote a statement that staff had seen Mr D throughout the day and they were not concerned about his breathing until teatime. The social worker also got the records from the 111 and out of hours service.

34. The Home's manager said Mr D was often deeply asleep over meal times, so his meals were kept for when he was awake. Ms P felt his deep sleep was of concern, when it was not. Care staff said Mr D was often short of breath following personal care, and it was at this time that Ms P told staff she was concerned about his breathing. The social worker noted that the transcript of the out of hours call said the staff said Mr D did not have frequent chest infections. The Senior Carer and nurse said they thought they had said that he had a history of chest infections.

35. The social worker concluded that they could find no evidence of neglect. They noted that whether staff gave incorrect information about Mr D's history of chest infections did not affect the fact that emergency services were called.

36. The social worker called Ms P on 11 July and explained they found no evidence that the care staff acted inappropriately. Ms P said she appreciated that there was a lack of evidence, but she felt strongly that the Home did not get Mr D to hospital quickly enough.

37. Ms P called the Council on 21 July. She said she was not happy with the outcome of the safeguarding investigation. The social worker agreed to contact the Home. On 24 July the social worker spoke with the Home's manager. The Home's records say the social worker would meet with Ms P and the Home to discuss various concerns (related to the way Ms P fed Mr D), but he was admitted to hospital before this happened.

38. On 15 August the Council recorded that Ms P called to say she understood the social worker may not want to pursue the safeguarding investigation further, but she considered that her concerns were justified. She said she did not want to make a complaint or further action to be taken.

Findings about the Home

39. Ms P said the Home's carers told her they heard a problem with Mr D's breathing in the morning. The Home provided a copy of statements by the carers who saw Mr D that morning. One said Mr D was quite wheezy, which they had mentioned to Ms P, but this was normal for him in the morning and he did not seem worse than he did at other times. The other also said that Mr D was a little chesty in the morning, but this was normal for him and they did not worry because they knew once he was sitting correctly it would settle down.

40. Having considered the evidence, I find that there was no reason for the Home to seek medical attention for Mr D based on the observations of the carers in the morning.

41. The Senior Carer documented in the Home's records at 15:27 that Ms P said Mr D sounded "chesty/wheezy" so she would phone the GP if they saw further wheeziness. Ms P says the Senior Carer told her she would call the GP for a home visit, and that when she rang the Home later in the afternoon the Senior Carer said she was waiting for the Practice to get back to her. The accounts of this discussion conflict. I cannot resolve these two differing accounts without any additional evidence, and there is no such evidence available. In these circumstances, I cannot establish that there was fault here.

42. Mr D was at significant risk of aspiration because of his medical conditions, and aspiration does not always cause coughing. Therefore, the Home needed to be alert to possible signs of aspiration. The Senior Carer should have reported Ms P's concerns to Nurse B, which should have prompted Nurse B to monitor Mr D's respiratory rate, temperature and oxygen saturation levels to check for signs of aspiration.

43. In its comments on a draft of this decision, the Home told me the Senior Carer did report Ms P's concerns to Nurse B, who carried out physiological observations, but they did not document this. Based on the evidence I have seen, I am not persuaded by this.

44. I find that the Home failed to properly respond to Ms P's concern by ensuring that the nurse was aware of Ms P's observation and that the nurse monitored Mr D's physiological signs as a result. This was fault, and was a potential breach of the fundamental standards of care.

45. The records say the Home's staff saw Mr D several times during the afternoon and did not see cause for concern about him, which indicates that they did not witness the abnormal sounds Ms P heard.

46. Signs of aspiration pneumonia can develop very quickly, and we do not know at what time during that day Mr D's physiological observations would have become abnormal. Therefore, it is possible that if a nurse had checked them soon after Ms P reported her concerns to the Senior Carer they would have been normal. Therefore, I cannot say that the Home would have found cause to seek immediate medical attention for Mr D were it not for the fault. This means I have not found that the Home's fault affected the course of Mr D's illness or put him at increased risk.

47. When the carers saw that Mr D seemed unwell in the evening, the Home promptly sought medical assistance for him. Ms P complained that the Home did not tell the out of hours service that he'd had breathing difficulties earlier that day. But the records show that the Senior Carer told the out of hours service that Ms P said he was chesty earlier in the day. I have not seen evidence of fault with the way the Home responded after staff saw that Mr D was unwell.

Findings about the Practice

48. There is no fault with the GP discussing Mr D with the Senior Carer rather than going to see him in his room. It is usual practice for GPs to discuss patients with care home staff and to make decisions based on what care home staff report, without necessarily seeing each patient in person.

49. When the receptionist told the GP that Ms P was concerned about Mr D wheezing, the GP correctly asked the receptionist to speak with the Home and find out whether Mr D needed a visit. However, reception staff did not do this until the following morning. Further, the GP did not follow up the request that afternoon by asking the receptionist whether the Home said Mr D needed a visit or not. By the time the Practice contacted the Home to offer a visit, Mr D was in hospital. The Practice was at fault here, because it did not follow good practice for the circumstances.

50. Since the Home was not concerned about Mr D at the time Ms P attended the Practice, it would probably have said he did not need a visit, had the Practice contacted the Home when it should have. Even if the Home had acted without fault and checked Mr D's observations when it should have, and it had found an abnormality, the Home would then have had to consider contacting the Practice

or emergency services itself, rather than waiting for the Practice to call back. Therefore, I have not found that the fault by the Practice caused an injustice.

51. The Practice completed a significant analysis of this event, but not until December 2018, after Ms P brought her complaint to the Ombudsmen. The analysis is inadequate because it does not contain a thorough review of what went wrong and fully identify what the Practice needed to do to prevent similar incidents.

Findings about the Council

52. The records show that the safeguarding officer discussed Ms P's concerns with her and considered what she said. They also considered information from the out of hours services and reviewed the Home's records. The Council's records do not suggest it planned to discuss Ms P's safeguarding concerns with her further at a meeting at the Home.

53. Having considered the evidence, I can find no fault with the way the Council reached its decision to find that the safeguarding concerns were not substantiated. I have not seen evidence of bias or a failure to take Ms P's concerns seriously. I have not seen any indication that the Council should have done anything differently which may have prevented the August incident.

Conclusions about the April incident

54. There was fault because staff at the Home failed to properly respond to Ms P's concern by ensuring that a nurse monitored Mr D's physiological observations.

55. It is not possible to know whether earlier monitoring would have shown signs that Mr D was unwell, so I have not concluded that the Home should have sought medical attention for Mr D earlier. Even if it had, it is likely that Mr D would still have become very unwell and needed an emergency hospital admission for treatment. However, the uncertainty around this is a source of distress to Ms P, and that is an injustice to her.

56. The Practice is at fault for failing to appropriately follow up Ms P's concerns, but this did not allow Mr D's condition to become worse or put him at increased risk.

57. There was no fault with the Council's safeguarding investigation.

Complaint about the events of August 2017

Ms P's complaints

58. Ms P said:

- Mr D became very unwell during the morning of 19 August 2017, but the nurse on duty at the Home in the daytime (Nurse K) was not concerned.
- The local out of hours service told the nurse on duty that night (Nurse Q) to call 999 for an ambulance for Mr D, but she did not.
- As a result, Mr D lost the chance to survive his illness.
- No one referred Nurse Q to the Nursing and Midwifery Council (NMC), the professional regulator for nurses, so she had to do this herself.
- The safeguarding investigation only looked at the actions of Nurse Q. It did not look at the actions of Nurse K, who did not take seriously Ms P's concerns that Mr D was in an altered state of consciousness and could not swallow pureed food that day.

The records

59. The Home's records of 19 August show staff provided care to Mr D throughout the day. He chatted with staff, ate food, drank fluids and passed urine.

60. At 00:25 on 20 August, a carer noted Mr D was breathing hard, seemed to be in pain, and was not responding. They told Nurse Q.

61. Nurse Q called 111 at 00:46. She said Mr D was not responding when spoken to, when he was normally alert at night. His blood pressure was a bit high, his eyes were a bit sunken, his breathing was not good and she could hear some bubbling. The 111 service said it would arrange a call back from an out of hours doctor.

62. The out of hours service called Nurse Q at 00:53. Nurse Q said Mr D did not "look too good at all". He was lethargic, drowsy, and his breathing was not very good. He had been this way for "about a couple of hours". At this point the call recording stopped for about 30 seconds. Then, the out of hours service asked Nurse Q whether Mr D had been eating and drinking. She said his intake was quite poor. The out of hours service told Nurse Q she needed to phone an ambulance because Mr D probably had sepsis. Nurse Q confirmed she understood.

63. The hospital records contain notes provided by the Home. Nurse Q recorded at 01:30 that she was called to Mr D's room because carers were concerned that he was lethargic, not his usual self, and they had seen him trying to vomit. Nurse Q recorded Mr D's pulse at 103, blood pressure at 181/72, and temperature at 36.3. She wrote that she called the out of hours service, which advised her to call 999 if his temperature increased. She checked his observations again after an hour. These were a pulse of 101, blood pressure of 161/88 and temperature of 36.7. Mr D appeared settled and asleep.

64. The out of hours service sent an incident report to the Practice, which said it had advised Nurse Q to call 999. It did not say she should only do so if his temperature increased.

65. At 07:56 on 20 August, Nurse K rang 999 about Mr D. She said Mr D was "not really conscious", breathing more deeply than usual, cold and clammy. She had come to work and checked on Mr D, after a report that Mr D was unwell the previous night. She recorded that when night staff called 111: "[111] was a bit busy so they just said to observe him".

66. An ambulance took Mr D to hospital. On 21 August, the hospital recorded that Mr D had severe sepsis. The hospital notes of 24 August say Mr D was not responding to treatment for infection, so it started end of life care. He sadly died the next day.

67. In October, Ms P complained to the Council, which started a safeguarding investigation. Ms P gave the Council a transcript of the call between the out of hours service and Nurse Q, where Nurse Q was instructed to call an ambulance. The social worker visited the Home and found no evidence that the Nurse Q took further action about Mr D's condition.

68. In January, Nurse Q contacted the social worker. She said there was a misunderstanding and she thought the advice from the out of hours service was to keep monitoring Mr D's temperature. The social worker noted that the transcript is very clear that Nurse Q was advised to call 999 and she confirmed she would. There was no record at the Home of the telephone call with the out of hours service, and no ambulance was called until the next morning when another nurse arrived.

69. On 31 January, the Council wrote to the agency which employed Nurse Q. It explained the findings of the safeguarding investigation about Nurse Q, and asked the agency to report the concerns to the NMC. The social worker noted that he spoke to the Home's manager on the phone, advised her about the concerns about Nurse Q's practice and asked the Home not to offer Nurse Q further employment.

Findings about the Home

70. The Home's records of 19 August indicate that there was no cause for concern about Mr D that day. Nurse K provided a statement on which she said Mr D did not appear to be ill at any time during that day. She said he took his medication as usual, and conversed with staff before and after Ms P visited. Though Ms P said she told Nurse K that she was concerned that Mr D was very sleepy, I consider that the evidence does not support a view that Nurse K should have sought medical attention for Mr D during the day.

71. The Home told me that Nurse Q maintains that during the missing section of the transcript of the phone call with the out of hours service, it told her to monitor Mr D's temperature and call an ambulance if his temperature increased. This reflects what Nurse Q documented in the notes the Home sent to the hospital. However, it does not reflect the content of the incident report the out of hours service sent to the Practice, and it is not consistent with the content of the rest of the transcript of the call.

72. Regardless, based on her observations that Mr D was less alert, unresponsive to voice, had laboured breathing, was in pain and was attempting to vomit, Nurse Q should have called an ambulance for Mr D by 01:00. Not doing so was fault, and appears to be a potential breach of the NMC Code. This caused a delay of around seven hours in his admission to hospital.

73. Had Nurse Q called an ambulance when she should have, the possibility that the hospital could have successfully treated Mr D's infection is slim. Given Mr D's very poor health, it is very likely that he would have died from the infection even if an ambulance was called at 01:00. Though I find it more likely than not that Mr D's death was not preventable, the delay did reduce his small chance of surviving the infection. The uncertainty around this caused significant distress to Ms P.

Findings about the Council

74. Ms P's complaint to the Council, following which it started the safeguarding investigation, did note that she felt Mr D was in an altered state of consciousness when she visited on 19 April, but she did not say at the time that the Home neglected him during that day. Her letter to the Council of October 2017 said her concern was the failure of Nurse Q to call an ambulance.

75. Accordingly, I do not find that the Council was at fault for not investigating the events of the daytime. In any case, the evidence from the Home and Nurse K indicates that there was no cause for alarm during that day.

76. The Council has provided evidence that it asked Nurse Q's agency to report the concerns about her to the NMC. Its letter contained details of the concerns. The Home said the agency requested documentary evidence of the Council's concerns and did not receive them, but this is not reflected in the Council's records.

77. I do not find fault with the Council here.

Complaint about the complaint handling

78. Ms P's key concern here was about the lack of an adequate response to her complaint about the Home's actions in April 2017.

79. Ms P wrote to the Home in October 2017 about her concerns, and had no response until March 2018, after she complained again. The Home then told her in May it was investigating her concerns and would write to her, then it refused to do so. This was fault. However, I have not identified an injustice from this, because Ms P's complaints were investigated by the Council and it is unlikely that a separate investigation by the Home would have made a difference to the outcome.

80. Ms P complained to the Council in October 2017, and the Council replied that it had reviewed the records of the safeguarding enquiry about the April events, and it considered that this had been handled properly. It explained its reasons for this in detail. The Council was entitled to reach this view, so I do not find fault with it.

Agreed actions

81. Within two months of this decision:

a) the Council will work with the Home to address staffs' understanding of how they should respond to relative's concerns, to prevent similar faults occurring in future. It will explain to Ms P in writing how it has done this. It will apologise to her for the impact of the Home's failure to respond properly to her concerns.

b) the Home will review its practice and procedures for monitoring the condition of patients who are unwell, or who may be unwell, and seeking medical attention. It will write to Ms P to apologise for the distress caused to her by the failure of Nurse Q to call an ambulance for Mr D and to explain the outcome of its review. It will share a copy of this letter with the Ombudsmen.

c) the Home will share a copy of this decision statement and its action plan with CQC and the Clinical Commissioning Group which funded Mr D's nursing care. It will provide evidence to the Ombudsmen that it has done this.

d) the Home will pay Ms P £500 to acknowledge the distress and uncertainty she was caused by the failure of Nurse Q to call an ambulance for Mr D.

Decision

82. I find that:

a) The Home failed to properly act on Ms P's concerns about Mr D's breathing. This was fault, and caused distressing uncertainty to Ms P, which is injustice. I find fault with the Council for this, since the Council commissions social care from the Home.

b) The Practice failed to respond properly to Ms P's concerns about Mr D's breathing. This is fault but did not cause injustice. It also failed to produce an adequate significant event analysis. This is fault but did not cause injustice.

c) The Home failed to call an ambulance for Mr D when it should have on 20 August. This reduced his chance of surviving his infection and caused significant distress to Ms P. I find fault with the Home for this, as this was a failure of nursing care.

d) There was no fault with the safeguarding investigations.

e) The Home failed to properly respond to Ms P's complaints. This did not cause injustice.

83. I am satisfied that the agreed actions will remedy the injustice I found. Therefore, I have completed my investigation. We will share a copy of this decision statement with CQC.

Parts of the complaint that I did not investigate

84. I did not investigate part f of the complaint, about the failure of the Home to supply a stool sample to Mr D's GP. There is no evidence that this caused a significant injustice to Mr D. The Home disagrees with the hospital's note of how frequently Mr D had loose stools when at the Home, and it is unlikely we could resolve this to Ms P's satisfaction.

Investigator's decision on behalf of the Ombudsmen

25 July 2019

Complaint reference:
18 019 648

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Mrs C complains on behalf of her son, Mr B, that the Council did not deal with his application for a blue badge properly. The Council was not at fault.

The complaint

1. The complainant, whom I shall refer to as Mrs C, complains on behalf of her son, Mr B, that the Council failed to deal with his application for a blue badge properly because it did not:
   - take into account his disabilities and the impact on his ability to access the community when it completed a mobility assessment.
   - consider how proposed changes to eligibility rules would automatically entitle him to a blue badge.

The Ombudsman's role and powers

2. We may investigate complaints made on behalf of someone else if they have given their consent. ***(Local Government Act 1974, section 26A(1), as amended)***
3. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***
4. We cannot question whether a council's decision is right or wrong simply because the complainant disagrees with it. We must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, section 34(3), as amended)***
5. If we are satisfied with a council's actions or proposed actions, we can complete our investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

6. I have spoken to Mrs C about his complaint and considered the information she has provided to the Ombudsman. I have also considered the Council's response to her complaint and its response to my enquiries.
7. I have written to Mrs C and the Council with my draft decision and considered their comments.

What I found

8. The Disabled Persons Parking Badge Scheme (known as the "Blue Badge scheme") was introduced in 1971. The Government later published The Disabled Persons Badges for Motor Vehicles (England) Regulations 2000 ("the Regulations").

9. The Department for Transport (DfT) has published non-statutory guidance for councils on the Blue Badge Scheme. This is called 'The Blue Badge Scheme Local Authority Guidance England October 2014' ("the Guidance").

10. The Blue Badge Scheme allows people with severe mobility problems and registered blind people to park close to their destination. Councils are responsible for the day to day administration and enforcement of the scheme. This includes assessing whether people are eligible for the blue badge.

11. There are two ways of qualifying for a blue badge. People qualify if they receive certain benefits. This is known as automatic qualification. People also qualify through an assessed route if they have a permanent and substantial disability which causes inability to walk or very considerable difficulty in walking.

12. The Regulations say councils may refuse to issue a badge if an applicant fails to provide evidence of a substantial disability. If the application is refused, councils must give the applicant 'particulars' of the grounds of refusal. The Guidance also says the Council should set out clear reasons for why the applicant did not meet the criteria.

13. The Guidance strongly recommends councils establish an internal procedure to deal with appeals, which needs to be clear, straight forward and fair.

14. The Guidance states that *'While medical conditions such as autism, psychological or behavioural issues… are not in themselves a qualification for a badge, people with these conditions may be eligible for a badge if they are unable to walk or have very considerable difficulty in walking.'*

Changes to blue badge eligibility

15. The Department for Transport (DfT) is introducing changes to the blue badge criteria so that some people with hidden disabilities will be eligible for a blue badge. The extended criteria are due to come into force on 30 August 2019.

16. One of the changes is a new eligibility criterion for people who score 10 points under the planning and following journeys activity of Personal Independence Payment (PIP).

17. The Council's website says, "If you believe you may be eligible under the new scheme please do not apply yet. Any applications made before the new criteria are introduced will be assessed against the current criteria and may therefore be declined."

What happened

18. Mr B suffers from Autism, learning disabilities and Epilepsy. He says this doesn't affect his mobility and he can walk reasonably well, but he requires constant supervision due to his behaviour.

19. Mrs C completed an application for a blue badge for Mr B. His application stated his disabilities and medication that he took. It also outlined the impact having a blue badge made a difference to him being able to go out.

20. The Council decided not to issue Mr B a blue badge. It said Mr B's medical conditions did not allow him to automatically qualify for a blue badge. The Council also explained how PIP scores would affect eligibility for a blue badge.

21. Mrs C appealed against the Council's decision. She understood that Mr B's PIP score meant he did not automatically qualify for a blue badge. Mrs C said a blue badge enabled Mr B to make journeys and go out because he had a hidden disability and needed two people to accompany him at all times. She said she felt the Council had not taken into account Mr B's needs or safety and provided more information.

22. The Council considered Mr B's appeal and made enquiries with Mr B's respite carers. It invited Mr B for an Independent Mobility Assessment (IMA).

23. The Council did not agree to issue Mr B with a blue badge. It said the mobility assessment suggested he did not meet the eligibility criteria for a blue badge. It also referred to the IMA and the observations of Mr B's walking ability.

Analysis

24. Mr B's disabilities were taken into account at both the initial application and appeal. Case notes also show that symptoms affecting Mr B's access to the community were also considered after his appeal. The Council consulted with Mr B's Day Services and sought their views.

25. A written record was kept of the IMA. The assessor was aware of Mr B's disabilities and difficulties accessing the community. Mrs C was present at the assessment. The IMA showed that Mr B had little difficulty walking.

26. The Council's final decision letter was clear and included reasons, based on the IMA, why the decision had been reached.

27. The Council's website has guidance about eligibility for blue badges. The Council's website says applications will be determined under the existing criteria.

28. Mr B received PIP. He scored 12 points in the 'planning and following a journey' section and 0 points in the 'moving around' section. Mr B's PIP scores do not allow him to automatically qualify for a blue badge under the current eligibility criteria. Under the new criteria due to come into effect in August 2019, Mr B may qualify for a blue badge under the new criterion. "*people who score 10 points under the planning and following journeys activity of Personal Independence Payment by virtue of being unable to undertake any journey because it would cause overwhelming psychological distress to the claimant*."

29. The Council says the transition of individuals from higher rate Disability Living Allowance (DLA) to PIP did not coincide with the new Guidance taking into account "*hidden disabilities*". At the time of assessment the Council says the changes to eligibility were unknown.

30. The Council assessed Mr B according to eligibility criteria in place when he applied and followed the advice published on its website. The Council was not at fault in how it dealt with Mr B's application for a blue badge.

Final decision

31. The Council was not at fault in how it dealt with Mr B's application for a blue badge. I have now completed my investigation.

Investigator's decision on behalf of the Ombudsman

31 July 2019

Complaint reference:
18 016 793

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman upholds the complaint from Ms X about the delay in assessing her children's need for adaptations. The Council took too long to allocate an occupational therapist and make a referral to the district council. It also delayed in deciding how much it would contribute to the work. The Council will apologise to Ms X and pay her and her children in recognition of the impact on them all of the delay. It will offer assessments to any other eligible children in the household. The Council will also provide additional training to staff about overcrowding and take action to reduce the time taken to allocate an occupational therapist in future.

The complaint

1. Ms X complains the Council delayed in allocating an occupational therapist to assess her children's need for adaptations to the family home. She is unhappy there have been further delays in applying for a disabled facilities grant. Ms X says the delay is having a negative impact on the wellbeing of her children and her as their carer.

The Ombudsman's role and powers

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

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

How I considered this complaint

4. I considered the complaint made by Ms X and the documents she provided.

5. I considered the Council's comments about the complaint and the documents it provided in response to my enquiries.

6. I also considered the Ombudsman's focus report, 'Making a house a home: Local Authorities and disabled adaptations' published in 2016.

7. I have given Ms X and the Council an opportunity to comment on my draft decision.

What I found

Legislation

8. The Chronically Sick and Disabled Persons Act 1970 places a duty on councils to provide assistance to residents in arranging adaptations to their home, or in providing additional facilities to help them live more safely, comfortably or conveniently.

9. If a child needs specially adapted housing, an occupational therapist will assess them to decide what their needs are. Occupational therapists usually work for the county council. They need to take account of other professionals' opinions to come to a view on the child's needs. Once a county council has assessed the child's needs, it needs to pass this information to the local housing authority.

10. Under the Housing Grants, Construction and Regeneration Act 1996 local housing authorities, in this case a district council, can award Disabled Facilities Grants (DFG) to people whose disability means their home needs adaptation. If the person applying meets the qualifying criteria the council must award the grant. The maximum grant is £30,000. Grants for children are not means-tested. Councils can decide to give more help if they think it is necessary.

11. 'Delivering Housing Adaptations for Disabled People: a detailed guide to related legislation, guidance and good practice' recommends target timescales for each stage. There are three stages:

- Stage 1 is from the enquiry at first point of contact to the Occupational Therapist (OT) referral. Their recommendations are provided to the adaptation service (landlord, housing association or grant provider).
- Stage 2 is from the OT recommendation to approval of the scheme.
- Stage 3 is from the approval of the scheme to the completion of the works.

12. The timescales vary according to whether the work is 'urgent' or 'non-urgent'. In urgent cases the target timescale from start to finish is 55 days. For non-urgent cases the process should ideally complete within 150 days.

13. District and county councils should work together to provide a well-coordinated DFG service. They should keep service users informed about progress including any problems arising. The Ombudsman considers the duty to meet assessed eligible needs is only met when adaptations have been satisfactorily finished.

14. The law on overcrowded households is in Part X of the Housing Act 1985. Statutory overcrowding is calculated by lack of rooms or lack of space. The law provides a calculation according to the floor space and the number of people.

Nottinghamshire County Council's policy

15. The Council's policy guidance says requests for support are made to the duty team which makes an immediate decision whether to progress to an occupational therapy referral.

16. All referrals go on to an initial assessment which is completed within ten days. The outcome of the initial assessment is either no further action, a specialist occupational therapy assessment or 'fast track'.

17. If a specialist assessment is required, a senior occupational therapist or manager will decide on the level of priority. Priority one is for children with safeguarding needs. Priority two is for children with complex needs but who are not considered to be at risk if the occupational therapy assessment is not immediate.

18. Specialist assessments are allocated within six months of the initial assessment decision. The Council does not give a timescale for completion of the assessment.

What happened

19. Ms X has two young children, C and D, with a rare progressive condition. Both children need 24-hour monitoring and they are supported by several pieces of equipment which alert their carers to any change in their condition. They receive nutrition via a central line which puts them at high risk of infection. The children need prompt access to their local hospital if there is a sudden decline in their health.

20. The children live with their mother and siblings in a home owned by Ms X and her former partner. C sleeps in the dining room, and D sleeps in the living room. Ms X sleeps on a sofa between them. Ms X's two youngest children share the bedroom on the ground floor while the remaining siblings share the bedrooms on the first and second floor.

21. The children needed more specialist equipment to enable Ms X and others to continue to safely care for them. The living arrangements meant C and D had no privacy or space to spend time with their family. In early September 2016, Ms X contacted the Council asking for adaptations to her home.

22. The Council completed its initial assessment, of C only, on 15 September 2016 and recommended a specialist assessment. It decided the case was 'Priority two'.

23. The Council sent letters to Ms X on 1 December 2016 and 1 March 2017 as the case was still awaiting allocation. The case was allocated to an occupational therapist in early March 2017, within the six-month timescale set by the Council's policy guidance.

24. During a home visit in March 2017, the occupational therapist noted D also had significant needs that needed assessment. She suggested carrying out a joint assessment of both children.

25. Both C and D had several hospital admissions during this period. The occupational therapist was also waiting for information from health professionals to inform the assessment. She completed the assessment in September 2017.

26. In its response to me, the Council acknowledged it could have completed the referral for DFG to the district council at this point. It said it didn't do so because the district council required the occupational therapist to carry out a joint visit with one of its technical officers.

27. The actions of the district council are subject to a separate investigation by the Ombudsman.

28. An internal panel was held on 9 October 2017. The Council agreed for the occupational therapist to arrange a joint visit with a technical officer to consider a ground floor bedroom and bathroom adaptation.

29. The visit took place in the same week. The technical officers asked the occupational therapist to delay presenting the case to the district council's Disabled Facilities Panel, which considers all applications for grants likely to

exceed £10,000. This was so they could seek further advice from the district council's planning department and look at whether they could seek two separate grants for the children.

30. At the end of November 2017, the occupational therapist submitted her report to the Disabled Facilities Panel. In her report she set out the children's complex needs. The report outlines her recommendations to meet those needs. It does not make any reference to relieving overcrowding.

31. The first set of plans, showing alterations across the ground, first and second floor of the property, was issued by the district council in December 2017.

32. While the district council explored the possibility of adaptations and alternatives to adapting the property, the occupational therapist kept in regular contact with Ms X and officers on their progress.

33. In January 2018, the occupational therapy manager contacted the local clinical commissioning group to ask if it could provide any support for the adaptations given the extensive health needs of the children. The clinical commissioning group said it could not use its funding for adaptations.

34. The occupational therapist asked for a multi-agency meeting due to the lack of progress. This took place in April 2018. At the meeting, the district council said it could not adapt the current property and proposed several alternatives to Ms X. Ms X was very unhappy with the proposals and shared her concerns with the occupational therapist.

35. At the beginning of May 2018, the Council told Ms X it would support her with renting a more suitable property for six months while other options were being explored. The occupational therapist and Ms X continued to look out for suitable rental properties over the following months though it appears none became available.

36. Around the same time, the occupational therapist had a discussion with a senior manager at the district council. She asked if the district council could draw out a plan which showed the maximum space available on the existing property so they could look at any compromises which could be made on space. The district council agreed.

37. In mid-May the district council sent a new set of plans to Ms X without consulting the occupational therapist. The plans did not meet the children's needs.

38. At the end of May, the Council spoke to Ms X about the possibility of appointing a lead worker to act a single point of contact. The Council suggested the lead worker should be impartial as officers from both councils were heavily involved and invested in the case. Although the Council followed this up with Ms X who agreed it would be a good idea, no lead worker was appointed.

39. The district council sent a further set of plans in June 2018, which both Ms X and the occupational therapist felt largely met the children's needs with some minor adjustments. The plans showed changes across all three floors. Discussions began between the Council and the district council about funding an architect and a drainage survey to take the proposals forward. The district council eventually took responsibility for this.

40. Throughout the summer of 2018 there appeared to be confusion about whether the Council could apply for some funding from an integrated health and social care budget. Eventually it was told this fund was not available for adaptations.

41. The occupational therapist formally sent referrals to the district council for DFGs for both children on 24 August 2018. The recommendations mirror those in the submission to the Disabled Facilities Panel in November 2017, with the added proposal to create more space in the living room to meet the children's social needs. The referrals say the property is overcrowded and it would not be possible to progress adaptations without addressing this. The referrals recognise that a DFG cannot be used to address overcrowding.

42. In October 2018 the district council told the Council it would only fund the adaptations to the ground floor of the property. The Council queried this. It asked the district council if it was sure the children's needs could be met with the changes to the ground floor without addressing the housing needs of the rest of the family. It said it needed to understand how much the scheme would cost so it could decide about contributing to it.

43. The district council said the DFG was intended to meet the needs of C and D only. It said it needed written confirmation from Mrs X to say she was happy to proceed with looking at the adaptations to the ground floor only before it could generate costs.

44. There is no evidence either council sought this written confirmation directly from Mrs X or informed her of the district council's decision.

45. A fortnight later, the occupational therapist emailed the district council asking it to generate costs for the work to the ground floor, as well as separately costing up the works to the first and second floor.

46. The district council agreed to ask an architect to draw up plans for the ground floor so it could continue with the full grant application. It said it would ask for upper floor plans at the same time.

47. There then followed a period of limited communication from the district council, despite the occupational therapist and her manager making repeated requests for an update.

48. From January 2019 the situation progressed at greater speed with the appointment of an architect. Further plans were drawn up for alterations to all three floors of the property and these secured planning permission in early May 2019. The district council maintains its position that it will only fund the adaptations on the ground floor, which it considers will meet the needs of C and D. The plans are currently subject to a tendering process.

49. The Council has now confirmed it will provide a financial top up for the provision of eligible works through the DFG. It decided this before formal quotes have been returned. It has also agreed to provide financial support towards any interim housing arrangements while the works are carried out.

Analysis

50. Credit should be given to the occupational therapist in this case who clearly strived to achieve the best possible outcomes for the family and advocated strongly on their behalf.

51. However, the Council took too long to make a referral to the district council. The guidance says this should take 20 working days; the Council took almost 500 working days. Even allowing for some of the delays which were outside the Council's control, the time taken from Ms X first requesting support to the referral for DFG being completed is unreasonable. This has contributed to C and D spending too long living in accommodation which does not met their needs.

52. I consider the Council should have allocated the case within three months with a further three months for assessment. Holding an internal panel, carrying out a joint visit, and sending a report to the Disabled Facilities Panel should have taken less than eight weeks. The referral to the district council for DFG should have followed immediately afterwards. With this in mind, the delay in this case amounts to 66 weeks.

53. It is unclear at what point the proposals for adaptations changed from a ground floor bedroom and bathroom to a larger scheme. The Council should have been aware the DFG could only be used to meet the needs of C and D, and supporting a wider scheme of alterations served to unreasonably raise Ms X's expectations. This was fault.

54. The Council did not seek informed consent from Mrs X before telling the district council to proceed with drawing up costs across all three floors of the property. As a result, she lost an opportunity to make an informed decision about continuing with the DFG process. This also contributed to her raised expectations of what could be delivered via the DFG process. This was fault.

55. I cannot find fault in the Council's decision to only provide a financial top up for the works to the ground floor. It has a duty to assist residents in arranging adaptations to their home, but not to relieve non-statutory overcrowding.

56. However, the Council took a long time to decide it would only contribute to the agreed works. Had it decided sooner, Ms X would have been better informed about the shortfall in funding and may have been able to begin seeking alternative sources of funding sooner.

57. It is unclear what definition of overcrowding the Council has used in assessing Ms X's property. It does not meet the statutory definition of overcrowding. The Council has repeatedly referred to Ms X's home as overcrowded and this appears to have led to confusion and conflict in its discussions with the district council. The insistence on developing plans to address the alleged overcrowding has raised Ms X's expectations and created unnecessary delay.

58. The Council proposed a lead worker to support Ms X with communicating with the various parties involved but does not appear to have followed up on this. Ms X would have benefitted from having another officer to support her with liaising between the two councils. This would have relieved the pressure on her, and on the occupational therapist who appears to have fallen into the role of lead worker by default. This was fault.

Agreed action

59. Within four weeks of the final decision, to remedy the injustice caused by the faults identified the Council will:

- confirm with Ms X whether any of her other children might benefit from an occupational therapy assessment and if so carry out these assessments within three months.
- apologise to Ms X and pay her £500 in recognition of the distress and frustration caused by raised expectations and delay.
- pay £6,600 to Ms X for the children in recognition of the prolonged period C and D have been living in unsuitable accommodation; and the effect on the other children of living with restricted living space due to the Council's delays. In calculating this, I have noted our guidance on remedies which says where a

complainant has been deprived of modifications which would have improved his or her daily life, we will usually recommend a payment of up to £350 per month. I have proposed a sum based on £100 per week in recognition of the number of children affected.

60. Within eight weeks of the final decision, the Council also agrees to:

- issue guidance to staff on the statutory definition of overcrowding and remind them to be cautious about describing properties as overcrowded without first assessing them against this definition.
- remind staff to keep a written record of any meetings with DFG applicants.
- ensure that for future DFG referrals, it agrees with the district council who will act as key contact and confirms this in writing with the applicant.

61. Within six months of the final decision, the Council has agreed to review its resources, targets and procedures with a view to reducing the time taken to allocate an occupational therapist.

Final decision

62. For the reasons given in the Analysis section of this decision, I uphold this complaint.

Investigator's final decision on behalf of the Ombudsman

1 August 2019

Complaint reference:
18 016 787

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Miss B complains the Council did not provide the holiday care set out in her support plan. She says her father needed to go with her on one holiday and she had no support for another. The Ombudsman finds the Council at fault for not providing the care. We recommend the Council apologise to Miss B and make a payment to recognise the loss of service.

The complaint

1. The complainant, who I refer to as Miss B, complains the Council did not provide care for her to go on two holidays and visit her consultant, in line with her support plan. Miss B says her father had to accompany her on one of the holidays and to see her consultant. Miss B had to go alone on the other holiday, without any support. Miss B says the Council should pay her father the money it would have paid to the carers who should have supported her during the trips.

The Ombudsman's role and powers

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

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

How I considered this complaint

4. I considered the initial information provided by Miss B and spoke to her about her complaint. I then made enquiries of the Council. I sent a copy of my draft decision to Miss B and the Council for their comments.

What I found

Background

5. Miss B receives a support package from the Council to help with her daily activities. She is mainly supported by her father. However, the Council commissions care of 18 hours per week, where carers help Miss B access various activities and services in the community. Each year, the Council

commissions extra care to allow two weeks respite for her father. Miss B's support plan also provided for a separate two weeks for a carer to accompany Miss B on holiday.

6. In the past, Miss B always booked her holiday through the care agency. Miss B provides the agency with the dates and they arrange for a carer to accompany Miss B.

7. In May 2018, Miss B contacted the care agency and provided dates for two weeklong holidays she wished to take in the summer. One was at the start of August 2018 and the other at in the middle of that month. Miss B spoke to a male carer who had previously gone with her. That carer said he would be happy to go again on at least one of the holidays. However, when he tried to book this, his manager raised concerns.

8. The agency manager said it was not appropriate for a male carer to go on holiday with Miss B. She said none of the other carers were willing to go with Miss B because of issues with these trips in the past.

9. The agency contacted the Council in June 2018. It said Miss B wanted to book support to go away but did not give specific dates. It said it did not have staff who were willing to go with Miss B due to past issues, other than one male support worker but it did not consider this was appropriate.

10. Miss B and her father chased the care agency several times between May and the end of July 2018 to arrange the care. They said the agency should provide this care as the Council had commissioned them to do so. There were several delays between responses from the agency and appears to have been some confusion about what it was commissioned to provide.

11. One email from the care agency to the Council in July 2018, suggests the agency only thought it was commissioned to provide care at home to Miss B while her father had respite, not to support her on holiday. The correspondence does not show the agency received a clear response to this from the Council.

12. By the end of July 2018 Miss B had still not received confirmation that the agency would support her during her holiday at the start of August 2018. Her father therefore agreed to go with and support her during this holiday.

13. In early August 2018, a social worker from the Council emailed Miss B's father asking him to provide her with the dates for Miss B's next 'respite'. She said it was a new requirement that she would need the dates of each period of respite to commission the service on a case by case basis.

14. Miss B's father did not see the email until he returned from the holiday. He responded and complained the Council had not commissioned the agency to provide care for the holiday. He asked if any arrangements had been made for Miss B's second holiday in the middle of August 2018. I have not been provided with any response to this from the Council. The Council emailed the agency to clarify what the care plan provided. However, there is no mention in this email of Miss B's second holiday.

15. Miss B's father was not available to go away with her for the second holiday, so Miss B went on her own, without any support.

16. Further correspondence took place between Miss B's father and the Council about future arrangements. In October 2018 he said Miss B was planning to visit her neurological consultant between the end of November and start of December

2018. Miss B's support plan provides additional care to allow her to visit her consultant over the weekend, three times a year.

17. The agency also contacted the Council to say Miss B had requested the support away and check the situation in relation to this. The Council said it would commission this as soon as the agency confirmed it had adequate staff.

18. In mid-November 2018, the agency emailed the Council and Miss B to say it could not provide the support due to issues it had encountered in the past, logistical difficulties and the impact on carers. By this point it was too late to find another provider who would commission the care. A social worker emailed back to ask if it could at least get her to the appointment. I cannot see a response from the agency.

19. The social worker then had a period of sick leave and it does not appear anyone responded to Miss B or her father about whether other arrangements would be made. Therefore, Miss B's father decided to accompany her again on her visit to the consultant in the absence of a support worker.

20. The Council has now discussed other alternatives going forward as the agency cannot provide care for the longer periods going away. The Council suggested setting up direct payments, whereby Miss B could commission her own care. However, her preferred option was for the Council to commission a different provider with the same arrangements. The Council has now found a potential alternative provider.

Findings

21. Miss B did not receive support for two holidays and a visit to her consultant, as outlined in her care plan. This is fault.

22. The Council produced a care plan that provided Miss B with support for holidays. This is a separate provision to the respite care that allows Miss B's father time away.

23. Miss B tried to book her holiday care three months in advance. She followed, what was at that time, the normal procedure for booking that care. The agency therefore had three months to either arrange the care or inform the Council it could not do so. It did inform the Council it could not do so in June 2018. It also questioned what care it was commissioned to provide.

24. I cannot look at why the care agency would not provide the care. It is the agency's decision whether it can do so. However, as Miss B provided plenty of notice of the dates she wished to book, more should have been done to resolve the matter or look for an alternative provider while there was still time to do so.

25. I appreciate the Council did not have exact dates for Miss B's holidays, but it was aware there were problems in June 2018 and does not appear to have provided a clear response to the agency until at least two months later. The Council is also responsible for the actions of any third-party provider it commissions to provide care. In this case, the agency did not provide clear information to the Council about when Miss B had asked to go away. It did not give a timeframe for when it needed to resolve the matter or start looking for alternatives.

26. Miss B did not receive care that was clearly outlined in her plan because of a breakdown in communication between the Council and the agency. Between them, the agency and the Council allowed the matter drag on until it was too late to make any other arrangements. There is evidence Miss B and her father chased

for the matter to be resolved through the normal channels several times, so I cannot say they contributed to this fault.

27. This caused injustice to Miss B in the sense that she lost a service the Council should have provided in line with the care plan. Miss B also spent avoidable time and trouble trying to resolve the matter. However, Miss B still went on both holidays and this limits the level of injustice caused.

28. The same applies for the trip to Miss B's consultant. Miss B provided more than a month's notice of the planned trip. The Council at first indicated it would commission this with the agency. It was not until a month later that the agency said it could not provide the care, by which point it was again too late to make any other arrangements.

29. The Council is responsible for commissioning care and for its delivery by any third party it instructs. In this case, again, the Council outlined support in Miss B's care plan, but she did not receive this because of a breakdown in communication that was not her fault. The fault therefore lies with the Council as the responsible body.

Consideration of Remedy

30. Miss B asks the Council to pay the father for the time he spent supporting Miss B on holiday, at the same rate it would have paid Miss B's carers. This suggests Miss B feels the main injustice is to her father, for the time he spent supporting her when he otherwise would not have done so. If not, Miss B asks the Council to pay her for the loss of service and says this should be at the same amount it would have paid the carers. She says, otherwise, the Council has benefited financially from not providing what is in her care plan.

31. I cannot recommend the Council pay Miss B's father for his support. The holiday provision is for Miss B and not for her father. Her father has a separate provision for respite of two weeks a year. Her father chose to go with and support Miss B during a period that did not include his own respite. I therefore cannot say the fault caused injustice to Miss B's father.

32. I recommend the Council pay Miss B for the loss of service. However, I cannot say this should be at the same amount it would have paid the carers. I understand Miss B's point that the Council will have benefited financially. However, we can only look at the personal injustice to her.

33. Miss B did not suffer any financial loss so paying her the amount the Council would have paid the carers would not put her back in the same position as before. We can only recommend the Council pay Miss B an amount to recognise the loss of service. The injustice in this case is limited because Miss B was still able to go on both holidays. I therefore recommend the Council apologise and pay Miss B £100 for the loss of service. I also recommend the Council pay Miss B £100 for the time and trouble she spent trying to resolve the matter, and in making other arrangements to be supported by her father on the first holiday.

Agreed action:

34. The Council has agreed to, within a month:

- Apologise to Miss B for not providing the service outlined in her care plan;
- Pay Miss B £100 to recognise the loss of service; and
- Pay Miss B £100 for time and trouble.

Final decision

35. The Council is at fault for not providing the service outlined in her Miss B's care plan. It will apologise and pay Miss B to recognise the loss of service and time and trouble.

Investigator's decision on behalf of the Ombudsman

5 August 2019

Complaint reference:
19 006 866

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman will not investigate Miss A's complaint that the Council's school admission appeal panel failed to properly consider her appeal for a school place for her son. This is because it is unlikely that we would identify fault on the Council's part.

The complaint

1. The complainant, who I will refer to as Miss A, complains that the Council's school admission appeal panel failed to properly consider her appeal for a school place for her son.

The Ombudsman's role and powers

2. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word 'fault' to refer to these. We cannot question whether an independent school admissions appeals panel's decision is right or wrong simply because the complainant disagrees with it. We must consider if there was fault in the way the decision was reached. If we find fault, which calls into question the panel's decision, we may ask for a new appeal hearing. ***(Local Government Act 1974, section 34(3), as amended)***

How I considered this complaint

3. I have considered what Miss A has said in support of her complaint and the appeal documents provided by the Council. I have also considered her response to my draft decision.

What I found

4. Miss A applied for a Year 3 school place for her son for September 2019 admission. The school to which she applied has an admission number of 25 and does not have a Year 3 intake. There were no vacancies in the relevant year group so the Council refused the application.
5. Miss A appealed against the Council's decision. She made a written submission and provided supporting evidence for the appeal panel's consideration. She attended the appeal hearing to make her case in person.
6. Independent school admission appeals panels must follow the law when considering an appeal. The panel must consider whether:
    - the admission arrangements comply with the law;

- the admission arrangements were properly applied to the case.

7. The panel must then consider whether admitting another child would prejudice the education of others. If the panel finds there would be prejudice the panel must then consider each appellant's individual arguments. If the panel decides the appellant's case outweighs the prejudice to the school, it must uphold the appeal.
8. The Ombudsman does not question the merits of decisions properly taken. The panel is entitled to come to its own judgment about the evidence it hears.
9. Having considered the cases made by Miss A and the Council's representative, the appeal panel decided to refuse Miss A's appeal. Miss A believes the panel was at fault, in that it based its decision on misleading information provided by the Council's representative. Specifically, she argues that the officer erroneously said the school's hall was not big enough to accommodate all the children and that the school has only one classroom on the first floor.
10. Miss A argues that the Council did not prove its case that the school was full. She points out that class sizes have exceeded 25, and that the school is below its capacity of 175. She also questions why the appeal panel allowed another appeal, but not hers.
11. The clerk's notes of the appeal hearing do not support Miss A's argument that the panel was at fault. The number of classrooms at the school was not in dispute, so their precise location is not significant. The admission number of 25 is derived from the measured capacity of the school, and the panel was entitled to conclude that the Council had proved its case that further admission would be prejudicial to the delivery of education at the school. The fact that some classes have exceeded 25 does not mean it is unreasonable to conclude that admission above this number is prejudicial.
12. Having made that decision, the panel went on to consider the individual cases. The notes show that Miss A was able to make her case and that the panel considered it. The weight the panel members chose to give to her evidence was a matter for them, not the Ombudsman. Without evidence of fault the Ombudsman cannot criticise the panel's decision or intervene to substitute an alternative view. Mis A believes the panel decided the case on her circumstances, not those of the school. The evidence shows that it considered both.
13. Appeals are considered on their individual merits. The fact that the panel allowed another appeal is not evidence of fault in the way it considered Miss A's case.

Final decision

14. The Ombudsman will not investigate this complaint. This is because it is unlikely that we would find fault on the Council's part.

Investigator's decision on behalf of the Ombudsman

7 August 2019

Complaint reference:
LGSCO: 18 008 760

Complaint against:
Nottinghamshire County Council
Mansfield and Ashfield Clinical Commissioning Group

Local Government & Social Care OMBUDSMAN

Parliamentary and Health Service Ombudsman

The Ombudsmen's decision

Summary: A woman complained that a council and clinical commissioning group did not work together to meet her care needs after she fell. She said this caused her health to worsen. The Ombudsmen find that the council failed to respond properly to her request for more support hours. There was a fault with the clinical commissioning group's communication. They have agreed to take action to remedy this.

The complaint

1. A woman I will call Ms P complained about the service she received from Nottinghamshire County Council (the Council) and Mansfield and Ashfield Clinical Commissioning Group (the CCG) following a fall in April 2018. She complained that the Council and CCG failed to work together to provide the care she requires to meet her complex needs. She said the failure of the Council and CCG to support her meant her physical and mental health deteriorated.
2. Ms P also complained that the Council would not agree to fund her visiting her family in Ireland with a carer.

What I have investigated

3. I have investigated the complaint about the way the Council and the CCG responded after Ms P fell. At the end of this statement I have explained why I have not investigated the other part of the complaint.

The Ombudsmen's role and powers

4. The Ombudsmen investigate complaints about 'maladministration' and 'service failure'. We use the word 'fault' to refer to these. If there has been fault, the Ombudsmen consider whether it has caused injustice or hardship ***(Health Service Commissioners Act 1993, section 3(1) and Local Government Act 1974, sections 26(1) and 26A(1)).*** If it has, they may suggest a remedy. Recommendations might include asking the organisation to apologise or to pay a financial remedy, for example, for inconvenience or worry caused. We might also recommend the organisation takes action to stop the same mistakes happening again.
5. The Ombudsmen have the power to jointly consider complaints about health and social care. Since April 2015, these complaints have been considered by a single team acting for both Ombudsmen. ***(Local Government Act 1974, section 33ZA, and Health Service Commissioners Act 1993, section 18ZA***

6. If the Ombudsmen are satisfied with the actions or proposed actions of the bodies that are the subject of the complaint, they can complete their investigation and issue a decision statement. ***(Health Service Commissioners Act 1993, section 18ZA and Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

7. The Ombudsmen cannot question whether an organisation's decision is right or wrong simply because the complainant disagrees with it. We must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, section 34(3), as amended, and Health Service Commissioners Act 1993, sections 3(4)- 3(7))***

8. The Ombudsmen cannot decide what level of care is appropriate and adequate for any individual. This is a matter of professional judgement and a decision that the relevant responsible organisation has to make. Therefore, my investigation has focused on the way that the decisions were made.

How I considered this complaint

9. I considered information provided by Ms P and information provided by the Council and CCG, including health and social care records and complaint files.

10. I shared a draft of this decision with the parties to the complaint and considered their comments.

What I found

Legal and administrative context

Community Care Assessment

11. Sections 9 and 10 of the Care Act 2014 require councils to carry out an assessment of any adult who appears to need care and support. The assessment must be of the adult's needs and how they impact on their wellbeing and the outcomes they want to achieve.

12. An assessment should be carried out over an appropriate and reasonable timescale taking into account the urgency of needs and a consideration of any fluctuation in those needs. Councils should let the individual know of the proposed timescale for when their assessment will be conducted and keep the person informed throughout the assessment process.

13. Where more than one agency is assessing a person, they should all work closely together to prevent that person having to undergo a number of assessments at different times, which can be distressing and confusing. Where a person has both health and care and support needs, local authorities and the NHS should work together effectively to deliver a coordinated assessment.

Community Care Eligibility criteria

14. The eligibility threshold for adults with care and support needs and carers is set out in the Care and Support (Eligibility Criteria) Regulations 2014. The threshold is based on identifying how a person's needs affect their ability to achieve relevant outcomes, and how this impacts on their wellbeing. For a person to have needs which are eligible for support, the following must apply:

    1. The needs must arise from or be related to a physical or mental impairment or illness.
    2. As a result of the needs, the adult must be unable to achieve two or more of the following outcomes:

- managing and maintaining nutrition;
- maintaining personal hygiene;
- managing toilet needs;
- being appropriately clothed;
- being able to make use of their home safely;
- maintaining a habitable home environment;
- developing and maintaining family or other personal relationships;
- accessing and engaging in work, training, education or volunteering;
- making use of necessary facilities or services in the local community including public transport and recreational facilities or services; and
- carrying out any caring responsibilities the adult has for a child.

3. As a consequence of inability to achieve these outcomes, there is likely to be a significant impact on the adult's well-being.

15. Where councils have determined that a person has any eligible needs, they must meet those needs. When the eligibility determination has been made, councils must provide the person to whom the determination relates (the adult or carer) with a copy of their decision.

Review of Assessment/Care Plan

16. Section 27 of the Care Act 2014 gives an expectation that councils should conduct a review of a care and support plan no later than every 12 months. A light touch review should be considered six to eight weeks after the plan and personal budget have been agreed. The review should be performed in a timely manner proportionate to the needs to be met. In addition to the duty on councils to keep plans under review generally, the Act provides a duty on councils to conduct a review if a request for one is made by the adult or a person acting on the adult's behalf.

Section 117 Aftercare

17. Anyone who may have a need for community care services is entitled to a social care assessment when they are discharged from hospital to establish what services they might need. Section 117 of the Mental Health Act imposes a duty on health and social services to meet the health and social care needs arising from or related to the persons mental disorder for patients who have been detained under specific sections of the Mental Health Act (e.g. Section 3). Aftercare services provided in relation to the persons mental disorder under S117 cannot be charged for. This is known as section 117 aftercare.

What happened

18. Ms P has physical and mental health difficulties, including limited mobility because of a stroke and heart problems. She is entitled to section 117 aftercare. She receives care and support from a care agency arranged by the Council.

19. In April 2018, Ms P had a care package of 27 hours per week. This included support with personal care, shopping and laundry, support to attend health appointments and support with social inclusion.

20. On 10 April Ms P fell and broke her arm. The following day, the Council noted that it would contact her to find out whether she had additional support needs. Ms P's care agency told the Council that for some time Ms P had used her support hours for social activities to cover her health appointments, which had increased over the past few months. Her care agency told the Council this left Ms P with little time for support with domestic tasks or social activities. She would now need

extra health appointments because of her broken arm. The Council allocated a social worker (the Social Worker) to carry out an urgent review.

21. The Social Worker visited on 20 April to review Ms P's social care needs. She noted she was coping well with her broken arm, but Ms P did not feel she had enough hours to manage her health appointments as well as social activities. Her care agency said they generally managed to make the 27 hours work but sometimes they provided additional unpaid support. Ms P and the Social Worker disagreed about whether the CCG was jointly funding her care, and the Social Worker agreed to check this. The social care review was not completed.

22. The Social Worker contacted the CCG. The CCG said Ms P's care was fully funded by the Council and the CCG would only review this if there was a significant change in Ms P's circumstances. This was because health and social care managers had agreed that "historical cases that were 100% funded aftercare will not be reassessed now". The CCG advised the Social Worker that assistance to get to health appointments was a social care need, not a health need. It said the Social Worker should make a referral to the CCG if Ms P's needs had changed.

23. In early May, the Social Worker told Ms P they would arrange a joint health needs assessment with the CCG. Ms P said she wanted an increase of 6 hours to attend her health appointments.

24. On 18 May, the Social Worker told Ms P she wanted to arrange to visit her with a nurse from the CCG. Ms P said she wanted the increased hours in place first. The Social Worker said any increase in her hours would need to be agreed by senior managers after the assessment. Ms P told the Social Worker she has having to cancel some health appointments because she could not manage them within her hours without having to sacrifice other tasks like her shopping.

25. On 23 May the Social Worker's manager (the Team Manager) told Ms P they could not guarantee that she would get the extra 6 hours she wanted because this would depend on the outcome of the forthcoming assessment.

26. The following day, the CCG told the Council it had advised Ms P that the referral to the CCG was because of her increased needs, but they could not guarantee that her care hours would increase until they had done the assessment and discussed her request for more hours with senior managers.

27. On 11 June, a nurse from the CCG, the Social Worker and the Team Manager visited Ms P. The nurse did a health needs assessment. She recorded that Ms P felt her social care needs were being met but that her health needs were not being met as she felt she did not have enough hours of support to help her attend her health appointments, which had recently increased. She wanted another 6 hours of support a week for this and said she could not attend all her appointments otherwise. The nurse told Ms P she was doing the assessment to determine whether the CCG would jointly fund Ms P's care, not to decide whether her hours would increase.

28. On 15 June Ms P called the Council, unhappy that the CCG had not considered the assessment yet. She wanted the Council to decide whether she could have the 6 hour increase to her support. The Social Worker told Ms P the Council was waiting for the outcome from the CCG. Ms P said the care should be agreed and the Council should work out the funding for it later. She said she felt stressed because she was clock watching whenever she went out with her carers. She was asking the carers to do her shopping for her because it was quicker, but it

meant she did not get out of her house. She did not know how she would manage to attend her forthcoming health appointments.

29. A few days later, the CCG told the Social Worker that its nurse had recommended that the CCG fund 30% of Ms P's care. However, if the Council did not decide to increase Ms P's care package the CCG would not contribute to the cost, since it would class this as an existing care package. Under the local agreement (referred to in paragraph 22) it would then stay with the Council to fund. The CCG said it did not think it unreasonable to provide Ms P with another six hours. It said the Council would still save money if it increased Ms P's care package and claimed 30% from the CCG. The Social Worker said she would discuss this with her manager.

30. The Council recorded on 25 June that it had decided to review Ms P's social care needs to understand more about her health appointments before it made a decision. The Social Worker told Ms P. She recorded that Ms P screamed and became hostile and critical of social care.

31. On 27 June, Ms P rang the Council to make a complaint. She said the Social Worker agreed in April that her needs had increased but she needed to discuss this with the Team Manager. Then, she heard that the Team Manager was referring her case to the CCG for funding. She had still not received any decision or extra hours. The Council had now told her she needed a new assessment, when it had already done an assessment in April. She said the Team Manager wanted to see whether her existing hours could be rearranged to cover support with her hospital appointments, but she felt she could not do this and still have hours left for personal and domestic tasks.

32. The Team Manager rang Ms P to say he and the social worker wanted to visit Ms P to review her care package. Ms P refused the visit, and said she wanted to meet with the social services director. She told the Team Manager she had cancelled her hospital appointments.

33. The Council's records of mid-July say the Council and CCG should jointly meet with Ms P to see what she needed and how the Council and CCG should split the funding, but Ms P was not willing to have another meeting. The CCG told the Council it had told Ms P that she needed an assessment to see whether she needed more hours, and that it had explained to her that support to access health appointments is a social care need rather than a health need.

34. The Team Manager rang Ms P to ask about her health appointments. Ms P rang the Council's complaints team to say she was unhappy with the Team Manager pressuring her for this information. She said the Council was not taking into account that she had slowed down since her last review and needed to use her wheelchair more. She said the Team Manager told her the Council did not identify that she needed more hours at her April review, but this was untrue because the Council asked the CCG for additional funding. Ms P then told the Council she would be prepared to have another review, but only if it was by a specific member of staff from another team.

35. Ms P's care agency contacted the Council on 17 July. It expressed concern that Ms P had not received the funding for additional support hours for health appointments. It said Ms P's health was deteriorating because she could not attend appointments, and the matter was causing Ms P "considerable undue stress".

36. On 18 July, the Council's records say a senior manager agreed to increase Ms P's care package by six hours a week to help her get to appointments. This was for a 4 month period to allow time for further work with Ms P to ensure her needs were met. Ms P said she only agreed to this if it was with someone she trusted, naming a particular member of staff.

37. The Council responded to Ms P's complaint on 26 July. It said it did not identify at her April review that she needed an additional 6 hours support a week. It said it found she had managed to attend the additional hospital appointments using her existing hours, though it acknowledged this affected the time she had available for social activities. The Council said neither Ms P or her care agency reported that her care needs were not being met. It wanted to look at the best means of supporting her to attend hospital appointments in future.

38. Regarding Ms P's view that her health and mobility had declined, the Council said it would look at this at a review, but it was difficult to do this since Ms P refused to meet with it and refused consent for it to consult with health professionals about her needs. It said to try to resolve the dispute, it agreed to put 6 hours additional support per week in place for four months from 6 August to allow time to complete a review and agree Ms P's long term needs.

39. When she received the response, Ms P called the Council to dispute that the 6 hours were not agreed in April. She said she had not refused to meet with the Council, she had agreed to meet with a specific member of staff. She asked for her care to be reviewed by that member of staff or a neighbouring local authority.

40. The Council wrote to Ms P again on 27 July. It said the CCG had not agreed to fund any additional hours, and its referral to the CCG was not related to Ms P's request for 6 additional hours. It said it did not agree to the specific member of staff or the other local authority reviewing her care, but said it had allocated an experienced social worker to support the Social Worker.

41. Records of early August say Ms P was low in mood and tearful. Her GP felt the trigger was her dispute with social services over her care hours. Ms P fell and injured her hip, and because of the combination of this and her other physical health needs she became bedbound.

42. Later in August, Ms P got a letter from the CCG advising that it would jointly fund her care. The CCG agreed to pay 30% of the cost. Ms P thought this meant her care hours would increase by 30%. The Social Worker explained that the CCG was contributing 30% of the cost of Ms P's care, and her hours were not increasing further. The Social Worker said they would update Ms P's review when her physical health had stabilised.

43. On 31 August, the Social Worker asked Ms P's care agency whether they could meet Ms P's needs within her agreed hours if they provided shorter, more frequent calls. The agency said it could but Ms P did not want this. She felt the Council should increase her hours because of the recent funding from the CCG.

44. Ms P brought her complaint to the Ombudsmen on 5 September. She said social workers visited her after she broke her arm. They said she may need more care hours and they would contact the CCG about this. Ms P said she told the Council she needed the additional hours straight away and should not have to wait for the CCG to agree them. The CCG refused the request, then agreed to fund 30% of her care in July. She said she previously had 27 hours per week, and with a 30% increase she should have 35.1 hours per week. She contacted the Social Worker for an urgent review because her care package did not cover the additional care

she needed after her hip injury. She said the Council suggested she had more frequent, shorter visits but this would make her more isolated. She said as a result of these events her mental health got worse.

45. On 14 September, Ms P took part in a review of her social care assessment and support plan. Her care agency said it considered that Ms P's needs could be met within the existing 33 hours per week. As Ms P was bedbound, she could not access community facilities or attend health appointments. Ms P said she felt she should have an increase in her care hours in line with the amount of funding from the CCG. The Social Worker explained that the CCG's contribution to the funding did not mean Ms P's care hours increased.

Findings and analysis

46. The Council recorded on 4 July that at the review in April it found that there was no immediate need to increase Ms P's hours because her broken arm did not affect her personal care, and the "CHC assessment" was part of an ongoing review of her support needs.

47. The Council did find that Ms P did not need more personal care because of her broken arm, but both Ms P and her care agency told the Council in April that her health appointments had increased and that before her broken arm she had already been using the hours allocated for other tasks to manage her appointments. Her appointments would increase because of the broken arm. The Council failed to identify that this meant her broken arm did potentially affect her care needs.

48. The Council recognised that Ms P was using the hours allocated to meet other assessed needs to manage her health appointments. But it does not seem to have recognised the potential impact on whether her other needs were met.

49. There was no good reason for the Council to require involvement from the CCG to review Ms P's social care support hours. As the CCG correctly told the Council, a need for support to attend health appointments is a social care need. Even if the Council felt it should seek funding from the CCG towards the cost of Ms P's care package, it should have properly assessed her social care needs and funded any additional hours she needed first. People should not have to wait for organisations to negotiate funding arrangements with one another before their needs are met.

50. The Council and CCG's communication with Ms P in May and early June reasonably led her to believe that the planned health needs assessment was to enable a decision about whether her support hours were increased. It is therefore unsurprising that Ms P was frustrated on learning that the Council and CCG decided after the health needs assessment that she needed another assessment. The Council decided in July that it needed more information about Ms P's health appointments. It could have got this any time from April.

51. Ms P's belief that the CCG's agreement to fund 30% of her care costs meant she should get 30% more care hours was mistaken. The agreement was that the CCG would fund 30% of the cost of the care hours the Council considered she needed. But the outcome of the April review was that Ms P felt she needed more hours and the Social Worker agreed to contact the CCG. The Social Worker told Ms P in June that it was waiting for the outcome of the CCG's health needs assessment before they decided whether she should have more hours. Therefore, I can understand why Ms P reached this belief.

52. The Council put the additional hours Ms P requested in place in July, which was a resolution to Ms P's immediate concern of not being able to access all her health appointments.

53. The Council was entitled to consider whether Ms P's care agency could meet her needs with her existing hours if they were rearranged. If Ms P felt this would increase her social isolation, she could have asked the Council to consider with her how her needs for social engagement could best be met.

54. I find that the Council is at fault for failing to adequately respond to Ms P's change in circumstances in April by properly considering whether it needed to increase her social care hours. I find that this led to a delay from April to July before the additional hours were agreed. The Council's response to Ms P's complaint said neither she nor her care agency had reported that her needs were not being met. This is incorrect. The records show that they had reported this several times. Therefore, there was fault with the complaint handling. This matter caused unnecessary stress and distress to Ms P. Her GP linked this to a deterioration in her mental health. This is an injustice to her.

55. I find that the CCG's communication with Ms P contributed to the confusion about whether the outcome of the health needs assessment might result in more support hours for her. It therefore contributed to the stress and distress this caused her. I have not otherwise found fault with the CCG.

Agreed action

56. Within one month the Council will write to Ms P to apologise for the impact of its faults on her. It will copy this letter to the Ombudsmen. It will pay her £250 to acknowledge the unnecessary distress and time and trouble she was caused.

57. Within two months the Council will review its practice and procedures for responding to reports that someone has increased needs, to ensure that it assesses the person's needs and puts any additional services they need in place promptly. It will write to Ms P to explain what it has done, and copy this letter to the Ombudsmen.

58. Within one month the CCG will write to Ms P to apologise for the impact of its fault on her.

Decision

59. I find that:

a) The Council is at fault for failing to properly respond to the change in Ms P's circumstances in April 2018 and for including inaccurate information in its complaint response. This caused unnecessary stress and distress, which is an injustice.

b) The CCG is at fault for miscommunication with Ms P about an assessment. This contributed to the stress and distress she experienced, which is an injustice.

60. I consider that the actions the Council and CCG have agreed to take will satisfactorily remedy the injustice I found. Therefore, I have completed my investigation.

Parts of the complaint that I did not investigate

61. I did not investigate Ms P's complaint that the Council did not fund her visiting her family in Ireland with a carer because I have not seen evidence that this was an assessed need, and it is unlikely that we would find fault here.

Investigator's decision on behalf of the Ombudsmen

12 August 2019

Complaint reference:
19 002 262

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: The Ombudsman will not investigate Mr A's complaint about the way he has been treated by the Council regarding his mother's, Mrs B's care. This is because the Ombudsman could not say there is any fault with the actions taken by the Council regarding the contact it has with Mr A and he does not have consent from Mrs B to complain on her behalf.

The complaint

1. Mr A says the Council has a vendetta against him and will not discuss his mother's care needs with him since he had cause to complain about the report prepared by Mrs B's social worker. Mr A says as Mrs B's carer the Council should discuss all concerns about her care and accommodation needs with him. Mr A says the Council should not have cancelled Mrs B's bank cards and should take action against the social worker who has a vendetta against him.

The Ombudsman's role and powers

2. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word 'fault' to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. We provide a free service, but must use public money carefully. We may decide not to start or continue with an investigation if we believe:

- it is unlikely we would find fault, or
- the fault has not caused injustice to the person who complained, or
- the injustice is not significant enough to justify our involvement, or
- it is unlikely we could add to any previous investigation by the Council, or
- it is unlikely further investigation will lead to a different outcome, or
- we cannot achieve the outcome someone wants.

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

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

How I considered this complaint

4. I considered the information and documentation Mr A and the Council provided. I sent Mr A a copy of my draft decision for comment.

What I found

5. Mr A complained to the Council about its decision not to speak to him about his mother's care and its failure to properly investigate his allegation that a social worker was rude and abusive to him.

6. The Council responded in May 2019. It explained Mrs B is deemed to have capacity, and without her consent, it cannot disclose any information about her to him or discuss any matters relating to her. Mr A says Mrs B suffers from mental ill health and has fluctuating capacity.

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

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

8. The Ombudsman could not say Mrs B lacks capacity to make decisions. Without consent from Mrs B confirming she wants Mr A to act on her behalf the Ombudsman will not investigate Mr A's complaint that the Council will not discuss her care needs with him.

9. If Mr A disputes Mrs B has capacity to make decisions about her care needs, he can ask the Court of Protection to consider his views. Information about the Court of Protection can be found on the website below.

   https://www.gov.uk/courts-tribunals/court-of-protection

10. Mr A is concerned the Council has not investigated his concerns about the abuse he says he received from Mrs B's social worker. The Council says it is correct the social worker has not communicated with him since January 2019. It advised Mr A this was because he was rude and abusive to the social worker during a call overheard by two senior staff members in the team. It confirmed it had noted Mr A's concerns about inaccuracies in the report regarding Mrs B's recollection she had broken her arm in the past, which he says she has not.

11. The Ombudsman was not party to the conversation and did not hear what was said in the phone call. While Mr A's recollection of what was said in the call differs to that of the social worker and those who witnessed it, the Ombudsman could not make a finding on this point when he was not there.

12. The Council wrote to Mr A in February 2019 and advised it is would not tolerate abusive and aggressive behaviour. It advised Mr A if he wanted to speak to someone about Mrs B's care he could meet with two staff members or speak to a duty Manager. Mr A can speak to staff about Mrs B and raise any concerns he has, so the Ombudsman could not say this is fault.

13. The Council explained to Mr A it knows Mrs B has delusional thoughts which is sometimes expressed as accusations. It always records what Mrs B says and if

serious enough, passes onto its Multi-Agency Safeguarding Hub (MASH) to make further enquiries. The Ombudsman could not say this is fault.

14. The Council explained Mrs B decided to change the way her finances were managed, and it cancelled the bank cards at her request. It says social workers planned to visit Mrs B regarding her care and her apparent decision to reverse the decision to allow Mr A access to her bank account and funds. However, it says Mr A refused to allow workers to speak to Mrs B alone, so it was unable to determine Mrs B's wishes. In the absence of permission from Mrs B allowing the Council to share information about her the Ombudsman could not say there is any fault.

15. Mr A says the Council is wasting his time travelling to different accommodation providers who it says can meet Mrs B's needs, but Mr A says she cannot afford. The Council has explained Mrs B is currently living in a short-term assessment placement and needs a permanent suitable accommodation which it is working to identify and secure. It has explained to Mr A it needs to consult and involve Mrs B in this process. The Ombudsman could not add to this or make a different finding even if he investigated. The Council has explained what it is doing to secure suitable permanent accommodation for Mrs B.

Final decision

16. The Ombudsman will not investigate this complaint. This is because the Ombudsman could not say there is any fault with the actions taken by the Council regarding the contact it has with him and he does not have consent from Mrs B to complain on behalf.

Investigator's decision on behalf of the Ombudsman

12 August 2019

Complaint reference:
18 014 304

Complaint against:
Nottinghamshire County Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Mr B complains about the Council's decision to place his late mother in residential care and to pursue the family for the cost of that care. The Ombudsman has found no fault by the Council in its decision or in charging the estate. The Council delayed in dealing with Mr B's complaint and has offered a suitable remedy.

The complaint

1. Mr B complains the Council wrongly decided to place his late mother, Mrs F, in permanent residential care in June 2017 and is now wrongly pursuing the family for the cost of that care.
2. Mr B says his mother was in reasonable health before she went into care, but sadly died following a fall at the care home. He considers her needs would have been better met if she had stayed in her own home.

The Ombudsman's role and powers

3. We investigate complaints of injustice caused by 'maladministration' and 'service failure'. I have used the word 'fault' to refer to these. We cannot question whether a council's decision is right or wrong simply because the complainant disagrees with it. We must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, section 34(3), as amended)***
4. If we are satisfied with a council's actions or proposed actions, we can complete our investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

5. I considered the information Mr B sent, the Council's response to my enquiries, and:
   - The Care Act 2014
   - The Care and Support Statutory Guidance ("the Guidance")
   - The Mental Capacity Act 2005 and its Code of Practice
6. I sent Mr B and the Council my draft decision and considered the comments I received.

What I found

Safeguarding adults

7. The law says councils must make necessary enquiries if it has reason to think a person may be at risk of abuse or neglect and if that person has needs for care and support which mean he or she cannot protect himself or herself. The enquiries should determine whether any action needs to be taken to prevent or stop abuse or neglect. ***(section 42, Care Act 2014)***

Mental capacity

8. The Mental Capacity Act 2005 is the framework for acting and deciding for people who lack the mental capacity to make particular decisions for themselves. It says a person must be presumed to have capacity to make a decision unless it is established that he or she lacks capacity. The council must assess someone's ability to make a decision when that person's capacity is in doubt.

9. If someone lacks capacity a “decision maker” must decide on their behalf. A key principle is that any act done for, or any decision made on behalf of, a person who lacks capacity must be in that person's best interests. The Act sets out the steps that decision makers must follow to determine what is in a person’s best interests. These steps include consulting close relatives. The Court of Protection may need to become involved where there are disagreements that cannot be resolved in any other way.

Deprivation of liberty safeguards

10. The Deprivation of Liberty Safeguards (DoLS) provide legal protection for individuals who lack mental capacity to consent to care or treatment and live in a care home, hospital or supported living accommodation. The DoLS protect people from being deprived of their liberty, unless it is in their best interests and there is no less restrictive alternative.

11. The code of practice sets out the procedure to follow to obtain authorisation to deprive an individual of their liberty. Without the authorisation, the deprivation of liberty is unlawful. It is the responsibility of the care home or hospital to apply for authorisation from the local authority within 28 days.

Lasting power of attorney

12. A Lasting Power of Attorney (LPA) is a legal document that allows people to choose one person (or several) to make decisions about their health and welfare and/or their finances and property, for when they become unable to do so for themselves. The 'attorney' is the person chosen to make a decision, which has to be in the person’s best interests, on their behalf.

13. There are two types of LPA:

- Property and Finance LPA – this gives the attorney(s) the power to make decisions about the person's financial and property matters, such as selling a house or managing a bank account.
- Health and Welfare LPA – this gives the attorney(s) the power to make decisions about the person's health and personal welfare, such as day-to-day care, medical treatment, or where they should live.

Financial assessment and charging

14. Councils can charge for care and support services they provide or arrange. People who have over the upper capital limit of £23,250 are expected to pay for the full cost of their care. The Guidance says councils are precluded from paying

towards the costs of care if a person is in a care home and the financial assessment identifies their resources exceed the capital limits.

15. Once a person's capital has reduced to less than the upper capital limit, they only have to pay an assessed contribution. Councils must assess the means of people who have less than the upper capital limit, to decide how much they can contribute towards the cost of their care.

Continuing healthcare funding

16. NHS Continuing Healthcare (CHC) is a package of care arranged and funded solely by the NHS. The first step in determining if someone is eligible for CHC funding is where a professional evaluates whether the individual may have enough needs to qualify. Eligibility for CHC does not depend on particular diagnoses or conditions. Rather, it rests on whether a person has a 'primary health need'. This is where a person's overall needs go beyond the limits of a local authority's responsibilities.

End of life care

17. When a person is approaching the end of life, they may be offered care in a variety of settings, such as at home, in a hospital or in a care home. If end of life care is to be provided at home, in a care home, or in a hospice, the person should be assessed for CHC.

What happened

18. Mr B's mother, Mrs F, was elderly and had dementia. She lived at home with her son, Mr G, who cared for her. Mrs F had a package of home care and attended Care Home 1 for day care. The Council had assessed her as having to contribute towards the cost of her care.

19. On 1 June 2017 the home carer raised a safeguarding alert with the Council following an incident involving Mr G. Mrs F was at Care Home 1 for day care. The Council started a safeguarding investigation and arranged for Mrs F to remain at Care Home 1 for two weeks emergency short term care. The Police were informed of the incident.

20. The Council assessed Mrs F's mental capacity and found she did not have the capacity to decide where she lived. It consulted Mr G who said he wanted Mrs F to return home, as this was where she could be best cared for.

21. The Council considered Mr G's views but made a best interest decision on 6 June 2017 that Mrs F should stay at Care Home 1 whilst the safeguarding investigation was carried out. The Council spoke to Mr G about paying for Mrs F's care if she were to remain in residential care in the long term. He asked whether the value of her property could be disregarded as he was still living in it.

22. The Council completed its safeguarding investigation. The incident was found to have occurred and the Council decided Mrs F would be at risk if she returned home. On 14 June 2017 the Council decided Mrs F should remain in residential care for the long term. Care Home 1 applied for DoLS authorisation, which was granted following a further assessment of Mrs F's mental capacity and of what was in her best interests.

23. The Council re-assessed Mrs F's finances. This found Mrs F had more than £23,250 capital and therefore had to pay for the full cost of her residential care.

24. Mrs F fell and broke her hip on 25 July 2017. She was admitted to hospital and discharged a few days later. Mr B says when he visited his mother on 29 July

2017 he was shocked at her condition. Care Home 1 sought medical advice and Mrs F was re-admitted to hospital. She was diagnosed with an infection and sadly passed away on 9 August 2017. The Council later sent her estate an invoice of £4,768 for eight weeks care from 14 June 2017 to 9 August 2017.

Mr B's complaint

25. Mr B complained to the Council in December 2017. He said when Mrs F was in hospital the family had been advised she would receive end of life care and that this was funded by the local authority.

26. The Council responded to the complaint in May 2018. It apologised for the delay in dealing with Mr B's complaint. The Council said end of life care was funded by the NHS if a person met the criteria for CHC funding. Mrs F had sadly died before this could be determined. Care Home 1 had not waived its fees whilst Mrs F was in hospital as her place had been kept open in anticipation of her return. The Council said as Mrs F had savings above the capital limit, her estate was liable for the costs of her care.

27. Mr B was dissatisfied and wrote again to the Council on 2 July 2018. He complained the Council had failed to take the family's views into account when making a decision to place her in permanent care. Mr G had told the Council he wished to continue caring for Mrs F at home and this had been her desire when she gave her children joint LPA. As the Council had made the decision, he considered the funding for her care was the Council's responsibility. Mr B said Mrs F's condition deteriorated rapidly once admitted to Care Home 1 and she had fallen several times.

28. The Council responded in February 2019. It again apologised for the delay and offered to remove £400 from the outstanding balance of Mrs F's charges to acknowledge this. The Council did not uphold Mr B's complaint. It said the DoLS assessment and best interest decision were completed in accordance with the legislation. Mr B complained to the Ombudsman.

My findings

29. Mr B disagrees with the Council's decision to place Mrs F in long term residential care. He says this was not in her best interests and was against her wishes. The Ombudsman's role is not to decide what was in Mrs F's best interests. My role is to consider whether there was administrative fault in the way the Council made its decision. I have therefore considered how the Council carried out the safeguarding investigation and how it made the best interest decision.

30. As part of the safeguarding investigation the Council took evidence from the home carer, Mr G and the Police. The investigation report sets out what happened. It found the allegation was substantiated and that Mrs F would be at risk if she returned home.

31. I am satisfied the safeguarding investigation was thorough, proportionate and in line with the Guidance. For this reason, I cannot criticise the Council's decisions that the allegation was substantiated or that Mrs F would be at risk if she returned home. These were decisions it was entitled to make based on the evidence before it.

32. The Council then took a best interest decision that Mrs F should be in residential care for the long term. I have seen no evidence it failed to follow the procedures set out in the code of practice. It consulted Mr G and his sister; the evidence shows the Council knew Mr G's view was that he wished to continue caring for Mrs F at home. Mr B or his siblings did not have a LPA for health and welfare and

the Council was not required to consult all family members. Care Home 1 applied for DoLS authorisation in line with the code of practice. The Council granted this following an assessment of Mrs F's mental capacity. There was no fault by the Council in the way it decided Mrs F was to be in residential care.

33. In response to my draft decision, Mr F said the Council had not applied to the Court of Protection for permission to keep his mother in residential care. It was not required to do so. Applications to the court to get an order authorising the restriction of someone's freedom are needed only if the person is not in a care home or hospital.

34. Mr B says the Council is responsible for the cost of the residential care. The Guidance says where a local authority arranges care and support to meet a person's needs, it may charge the adult, except where it is required to arrange care and support free of charge. No such exemptions applied in Mrs F's case. The Guidance also says councils may not pay for residential care if the person's savings are above the capital limit. I have considered the financial assessment carried out by the Council in June 2017. I have seen no evidence of fault in the way it was done. There was therefore no fault by the Council in charging Mrs F's estate.

35. The Council is correct that end of life care is not funded by local authorities. It may be funded by the NHS following a CHC assessment. Unfortunately, Mrs F died before that assessment could happen. It was therefore not fault for the Council to charge Mrs F for the cost of her care.

36. The Council has accepted there was a significant delay in dealing with Mr B's complaint. It has apologised and offered £400 to remedy the injustice caused. This is an appropriate and proportionate remedy in line with the Ombudsman's guidance.

Final decision

37. There was no fault in the Council's decision to place Mrs F in residential care or to charge her for the cost of this care.

38. There was fault by the Council in the way it dealt with Mr B's complaint. The Council has offered a suitable remedy.

39. I have completed my investigation.

Investigator's decision on behalf of the Ombudsman