

Section J: Social services

J1: Adoption

Termination of introduction process – communication – complaints procedure

1. Ms Strachan complained that a council terminated the introduction process between herself and a child she hoped to adopt, Jane, without good reason, without proper notice and without adequate explanation. She also complained that the council then did not properly investigate her complaint about the way in which it dealt with her application to adopt Jane.
investigation report and at the review panel hearing.
6. The Ombudsman found that the review panel itself acted impeccably in trying to clarify the complaint, elicit information, explore the relevant issues and provide Ms Strachan with a full and proper opportunity to express her concerns.

The council's decision

2. The Ombudsman saw that, on the available evidence, she could not conclude that any omission or improper action of the council was wholly or directly responsible for the failure of the introduction process. The council's decision to terminate the process was not unreasonable.

Communication

3. But the Ombudsman said that the council failed to communicate with Ms Strachan in an adequate and effective way.
4. The council failed to notify Ms Strachan properly of its reasons for terminating the introduction process, sent her a letter which was insulting to her intelligence and insensitive to her feelings, and took deliberate action to cause the adoption agency to withhold its full letter of explanation. The council offered no satisfactory explanation for its actions in this respect.

Complaints procedure

5. The council's investigation of Ms Strachan's formal complaint was inadequate, incomplete and biased. The council omitted or misrepresented crucial facts during the stage two investigation; some facts were also omitted from or misrepresented in the

Confidential information

7. The council allowed Jane's foster parents full access to Ms Strachan's adoption form. The Ombudsman commented:
"Whilst it may be perfectly proper for a foster carer, who has an in-depth knowledge and understanding of a child, to play some part in the selection process of a suitable adoptive parent, I can see no justification nor statutory basis for extending this to providing the foster carer with detailed personal and confidential information about the prospective adoptive parent. It appears to me to be totally inappropriate and unprofessional for such confidential information to be made available to anyone other than the most essential personnel."
8. The council's action exposed Ms Strachan to unnecessary and unwarranted intrusion into her private affairs. The Ombudsman noted that the council had now stopped this practice.

Outcome

9. In recognition of the difficulties Ms Strachan had experienced and the expenses she had incurred, the council agreed to pay her £500.

(Report 97/C/3985)

J2: Aftercare services

Discharge from hospital after compulsory detention – aftercare – whether charging lawful – change of policy

1. Mr Hughes complained on behalf of his sister, Miss Hughes, that a council wrongly charged her for residential care costs. As a result, Mr Hughes said he was forced to sell his sister's property in order to meet the costs of her care.

What happened

2. In June 1994 and then again in January 1995 Miss Hughes was compulsorily detained in hospital under section 3 of the Mental Health Act 1983. After her discharge, she was settled in a residential home so that she could be properly looked after to avoid the need for detention in hospital in future. This aftercare was provided under section 117 of the 1983 Act. The council charged Miss Hughes for the aftercare and the main issue in the complaint was whether it was in fact open to the council to do so.

Court action

3. The issue of charging for aftercare services was considered in the High Court in July 1999 in a case involving four separate local authorities. The High Court ruled that charges could not be made for aftercare services, including accommodation, provided under section 117. That decision was appealed to the Court of Appeal and the outcome was not known at the time of the Ombudsman's report.

The council's policy

4. When the aftercare provision began in May 1995 it was the council's policy to make charges. The officers knew that the Department of Health had advised that services provided under section

117 could not be subject to charging. They therefore sought legal advice on the council's charging policy.

5. In-house legal advice confirmed that no charges for these services could lawfully be made. That was confirmed by a Counsel's opinion in March 1996.

6. The council changed its policy and agreed not to make charges. But that change was not agreed until April 1998. The Ombudsman could see no reason why, with reasonable diligence, the policy could not have been changed some two years earlier than it was.

7. The Ombudsman commented that this was a case where reasonable diligence was required because Miss Hughes – and she would not have been the only person in this kind of position – was being required to pay £256 a week for services which the council's legal adviser said should have been provided free of charge. Her home had to be sold to meet the costs which amounted to some £60,000.

Reimbursement

8. The Ombudsman said that, when the council decided to change its policy, it gave inadequate consideration to reimbursing charges already paid by people receiving section 117 aftercare. The report which the council considered proposed that client contributions already received should not be reimbursed, but did not say why that was thought to be an appropriate approach. The Ombudsman concluded that the report did not do justice to considering the council's obligations to people who had paid for their care in circumstances where its legal advice was that it had

to provide services free of charge. That inadequate consideration was maladministration.

9. The Ombudsman considered on balance that proper consideration of the council's obligations to Miss Hughes would have led to reimbursement of all her costs up to April 1996, at which point the policy should have been changed anyway. This was because the only advice in front of the council was that it had never had a legal basis for charging. But the Ombudsman did not think that this particular element of Miss Hughes' costs should be reimbursed if the courts finally determined that charges were lawful.

Retrospective decision on status

10. When the policy was changed in 1998, the council reassessed Miss Hughes' care status. It decided retrospectively that she had not been subject to a care programme after July 1996, when it considered she became self-funding. That decision was not made in accordance with the *Code of practice* issued by the Department of Health. In accordance with that guidance all those involved with the patient, including Mr Hughes, should have been consulted before any decision was made; and matters should have been kept under review until the care plan of May 1995 was no longer necessary. The Ombudsman could see no scope under the *Code of practice* for a retrospective judgement to be made, without consultation and review. The decision was made with

maladministration and, in the absence of a proper review conducted in accordance with the *Code of practice*, the Ombudsman considered that Miss Hughes had continued to receive services under section 117.

Conclusion

11. The injustice to Miss Hughes was considerable. The Ombudsman said that if the courts finally decided that there was no basis for charging under section 117, the council should pay for her aftercare from May 1995 until such time as a proper assessment concluded that her care was no longer provided under section 117. In that case, all her care costs should be reimbursed. If the courts decided that charges were lawful, Miss Hughes' care costs should be reimbursed from April 1996 – when the council was in a position to make the policy change it in fact made in April 1998 – until such time as the council changed its policy.

12. The Ombudsman commented:

"There will, no doubt, be others who are in a similar position. I urge the council to consider the cases of other people who have had to pay for these services and treat them in a similar way to that I recommend here."

13. The Ombudsman also recommended that an *ex gratia* payment of £500 should be made to Mr Hughes.

(Report 98/B/341)

J3: Day care

Review panel recommendation – need for urgent assessment accepted by council – delay

1. Mr and Mrs Rose complained that a council delayed unreasonably in carrying out the recommendations of a review panel which examined their complaint about the service provision for their daughter, Lily. Lily was an adult with learning difficulties.

What happened

2. The review panel recommended that there should be an urgent reassessment of Lily's needs. The council accepted the recommendation.

3. However, Lily's case was then dealt with in accordance with the council's normal scheme of priorities, which did not afford her any degree of priority. As a result, the assessment took 18 months and it was altogether two years before the new care plan was in place.

Faults by the council

4. The Ombudsman found that there were the following faults by the council:

- a failure even to allocate the task of Lily's assessment to a care manager for more than six months;
- delay in gathering relevant information for the assessment;

- delay in completing the assessment; and

- delay in sending the completed assessment to Mr and Mrs Rose.

5. The Ombudsman believed it should not have taken more than 12 months for the council to carry out the assessment of Lily's needs and draw up a care plan. Lily should have been in receipt of the level of day service provision identified in the care plan about a year earlier than she was.

6. Throughout this period Lily was receiving two or three hours a week of day care provision, but the new care plan specified a provision of five hours a week. Lily suffered the injustice of being deprived, for about a year, of the care that the council determined she was due.

Remedy

7. The Ombudsman recommended that the council should make a payment to Lily representing the cost of the day care provision which she was denied by the council's delay in carrying out the assessment. The Ombudsman also recommended a payment of £500 to Mr and Mrs Rose in recognition of their frustration and their time and trouble in bringing their complaint to the council and to the Ombudsman.

(Report 97/B/3440)

J4: Fostering

Social work support – preparation for adult life – access to records

1. Mrs X complained that a council failed to provide adequately for her care as a young person.

Background

2. Mrs X had been taken into the council's care as a very young child and placed with foster parents with whom she lived until she was 19. She made a number of detailed allegations about inadequate social work support during the placement, the loss of some of the files relating to the placement, and delay and fault in the way access was provided to the records that did exist.
3. Her complaint was the subject of a detailed investigation by the council under the statutory complaints procedure. The council accepted that there had been a catalogue of faults. The council apologised, offered a referral for life story work, offered some counselling, provided copies of available records over the previous 10 years, and paid Mrs X amounts she should have received in grants when she left care and which amounted to some £1,800.

Complaint

4. Mrs X believed that she should also receive compensation and complained

to the Ombudsman. She accepted most of the facts of the council's investigation so that it was only necessary to investigate those areas which she questioned. That investigation did not reveal any further fault by the council.

Outcome

5. The Ombudsman concluded that for about six-and-a-half years Mrs X was denied adequate social work support at crucial periods of her childhood and adolescence, and she was given no help by the council in preparing for adult life. The Ombudsman also considered that the faults had been compounded by the council's failure to provide proper support following a previous complaint, and that Mrs X had been put to unnecessary distress in seeking access to her files.
6. While it was not possible to be clear about exactly what would have happened if matters had been dealt with properly, the Ombudsman considered that Mrs X had suffered a serious injustice which should be recognised by compensation. The council accepted the Ombudsman's suggestion that it should pay Mrs X £7,500.

(Local settlement 98/A/4271)

J5: Fostering

Inadequate efforts made to secure a fostering placement – inadequate arrangements made for a temporary closure of a residential home

1. A solicitor complained on behalf of a young person in council care, Deborah, that the council failed to exercise its parental responsibility so as to provide appropriate care for her.

Care plan

2. Deborah's parents moved away leaving her in an unsuitable family situation with grandparents. The council prepared a care plan which identified long-term fostering as the best option.
3. The council was aware of a national shortage in fostering placements, and that it was particularly difficult to find suitable foster homes for teenagers.
4. The council had no suitable foster carer available when the care order was made, so Deborah was accommodated in a council-run children's unit.

Fostering

5. The Ombudsman said the council did not take sufficient action to find Deborah a suitable placement. When the care proceedings concluded, it should have been clear to everyone concerned with Deborah that there was no pool of suitable foster parents available within the council's area. For that reason, there should have been concerted action to find suitable places, such as local advertising specifically about Deborah, approaches to wider national networks and foster care agencies. Although it was known that it was most unlikely that a suitable foster home could be found within the council's area, no attempts were made to cast the net wider. The failure to pursue more actively a long-term foster placement, either within or outside the council's area, was maladministration.

The residential unit

6. Deborah was placed in the residential unit for a year. During that time the unit closed temporarily for refurbishment. Inadequate measures were taken to prepare Deborah for this. The Ombudsman said it was unacceptable that Deborah did not know of the closure of the unit until two weeks beforehand, and that at that stage the council had made no suitable alternative care arrangements. The Ombudsman commented:

"Even if a residential placement is not intended to be a child's permanent home, it seems to me essential that children should be fully informed about and consulted upon likely changes to their living arrangements."

Later events

7. Deborah was placed in a promising foster placement. Unfortunately it broke down. She was then placed in another children's unit where her behaviour began to deteriorate. After a period there Deborah expressed a wish to live with her mother, whose domestic arrangements had changed and who now had a new home. The council agreed to this.

Remedy

8. The Ombudsman said that the council's faults caused serious injustice to Deborah. She suffered uncertainty and worry over her long-term future and she remained for considerable periods in inappropriate placements. The Ombudsman commented:

"During her time in care, her social development has been severely compromised. No-one can know how

much these ill effects will damage her future life, but she will always know that the care she received from the council was inadequate and that she has been badly let down."

9. The Ombudsman recommended that the council should commission and pay for an assessment of any counselling or psychiatric help Deborah might need to recover from this difficult period in her life, and pay the reasonable cost of any counselling which was recommended.
10. The Ombudsman recognised that Deborah might not feel ready to accept an assessment of that sort immediately and recommended that the council should leave the option

open to her until she reached the age of 25.

11. The council was also recommended to pay Deborah £2,000 to reflect her distress, suffering and justified sense of grievance.

12. The Ombudsman concluded:

"The council should review its arrangements for fostering children in its care and satisfy itself that, as far as possible, its resources, policies and administration are adequate for the task, taking into account current best practice within local government."

(Report 97/B/771)

J6: Fostering

Failure to investigate allegations sufficiently – failure to review placement

1. Mr X was a vulnerable young man. He complained about the way a council investigated his complaint that he was assaulted by his foster carers' adult son. He also complained that the council refused to implement the recommendations of the investigating officer after his complaint had been investigated under the council's own procedures.
 - the carers' suitability to continue as carers was never reconsidered; and
 - the letter sent to Mr X following the internal investigation did not tell him how he could pursue his complaints.
2. The council accepted that:
 - it had not assessed the carers properly;
 - it had failed to draw up a care plan for Mr X;
 - it had failed to review whether the placement was appropriate, despite mounting concerns about it;
 - there was a lack of action to tell the placement team about the social worker's concerns;
 - the council's own investigation of the allegations was wholly inadequate;
3. The council agreed to pay £550 for a holiday for Mr X and was willing to commit a similar amount towards counselling for him.
4. The council accepted the Ombudsman's suggestion that it should also pay Mr X £250. The council prepared guidance on dealing with allegations of abuse of adult service users; reviewed its carers' assessment criteria and procedures with a view to reviewing all carers; and adopted the practice of telling all complainants how to proceed to the next stage of the social services complaints procedure.

(Local settlement 98/A/2037)

J7: Home closure

Home for elderly persons – consultation

1. Mrs Armstrong, and three other people from the village where she lived, complained that a council did not properly consult residents and their relatives before deciding to close a residential home for elderly people; and that the council considered inaccurate and incomplete information when making the decision.
2. The complainants said that, as a result of the council's actions, the residents of the home and their relatives were unable to have their views taken into account before the decision was made, and the village lost its only council-run residential home for elderly people.

Consultation

3. The Ombudsman noted that the Court of Appeal had held that residents of a care home should be consulted before a decision to close a home was made. The Court described the essentials of such consultation as:
 - that the residents should know that the closure of the home was under consideration well before the decision was made;
 - that the residents should have a reasonable time to put to the council their objections to the closure; and
 - that the residents' objections should be considered by the council.
4. In this case, the Ombudsman said that informing residents of the proposal 11 days before the relevant committee meeting, and their relatives six days before, was not sufficient to qualify as consultation. The council arranged for members of the public to address the

committee on the subject but that was not an adequate means of obtaining the views of the residents and their relatives about the effect the proposed closure might have on them.

5. The Ombudsman commented:

"I appreciate that the council had difficult decisions to make. I cannot say that those decisions would have been different if there had been consultation, but the failure to involve residents of the home and their relatives at an earlier stage has left them feeling that their views were not relevant to the decision."

Other points

6. The Ombudsman did not uphold complaints that the decision was the subject of a party whip; that the information put before the council was misleading; or that the council should have consulted other people in the village who were not directly affected.

Outcome

7. The council agreed to pay £100 to each of the three complainants who had relatives in the home before its closure, in view of the failure to consult them, and their time and trouble in pursuing the complaint.
8. The council also agreed to arrange a treat or outing for all those who were moved from the home in the village to another home, to be arranged with them and their relatives, which would bring them together.

(Report 98/C/2796)

J8: Mental health assessment

Request from parent – failure to explain implications – complaints procedure

1. Mrs Dean complained about the way a council responded to her request for help with her son's behaviour and about the council's consideration of her complaint.

What happened

2. Mrs Dean rang the social services department. She told the duty social worker that she was concerned about her son's behaviour. He had been increasingly difficult over the previous two to three years and had recently become dangerous. She described violent acts by her son and her fear that he would kill her.
3. In the light of what Mrs Dean said, the social worker decided to carry out a mental health assessment of Mrs Dean's son under the Mental Health Act 1983 and arranged for police officers to be present on the occasion of the assessment.

Communication

4. The Ombudsman accepted that it was reasonable for the social worker to conclude, from what Mrs Dean had told her, that an assessment would be appropriate and that the police should be involved.
5. The Ombudsman also accepted that the council had to be cautious about contacting Mrs Dean when her son might be at home, and sympathised with the council's explanation of the need to explain things in lay terms. The Ombudsman was satisfied, however, that Mrs Dean did not

understand before the assessment that the outcome might be either the compulsory detention of her son in hospital (if he would not agree to accept treatment voluntarily), or the provision of no treatment if her son would not accept it voluntarily and compulsory detention could not be justified. This was crucial because the Ombudsman thought it likely that, if Mrs Dean had properly understood the position, she would have chosen not to go ahead with the assessment, or would at least have wanted further discussion and time for thought before she reached a decision.

6. The Ombudsman found that the council was at fault in not ensuring that Mrs Dean adequately understood the possible outcome of an assessment. As a result, she did not make a properly informed choice.
7. This fault caused injustice to Mrs Dean. If she had decided to go ahead with the assessment on the basis of a proper understanding of what it would entail, she would probably have suffered less distress when the assessment took place. Alternatively, she might have decided that an assessment would not be appropriate and, again, would have been spared much distress.
8. On the other hand, the Ombudsman was satisfied that Mrs Dean exaggerated the gravity of the matter when she spoke to the social worker. If she had not done so, the council might not have felt the need to arrange an assessment quickly, or at all, and Mrs Dean might have been able to have the discussion which she said was

what she really wanted. So in the Ombudsman's view, Mrs Dean bore some of the responsibility for her distress.

Complaints procedure

9. Mrs Dean made a complaint to the council. An investigating officer undertook an investigation of the complaint and drew up a proposed report. The director of social services acted as adjudicating officer. He instructed the investigating officer to change her report. Later in the process, after the review panel had made recommendations, it was the director of social services who provided the council's response to those recommendations.
10. The Ombudsman said that if the director of social services was not satisfied that the investigating officer's report contained sufficient evidence and analysis to support her conclusions, he should have told her so and asked her if she wished to reconsider her report. In her covering note with the revised report the investigating officer expressed concern about how independent her role had been. The Ombudsman said the director of social services should have realised that the investigating officer was unhappy that her report in its final form did not truly reflect her own conclusions.
11. The Ombudsman recognised the difficulty for the investigating officer in disagreeing with her head of department. But she should have declined to present the final version of her report if she believed that it did not reflect the outcome of her investigation. The process of producing the report of the investigation, the Ombudsman held, was flawed.
12. The Ombudsman also considered it was unfair that the council's response to what was effectively an appeal against the director's decision at stage 2 of the process was taken by the director himself. It would have been proper for some other suitable officer to respond on the council's behalf to the review panel's recommendations.

Outcome

13. The Ombudsman recommended that the council should pay Mrs Dean £300, and that the council should have a procedure to ensure that, if unavoidably the director had to act as adjudicating officer at stage 2, someone else responded on the council's behalf to the recommendations of a review panel.

(Report 97/A/2239)

J9: Rehabilitation

Checking before placement – absence of detailed contract – statutory complaints procedure

1. Mrs Rose complained that a council did not do enough to help either her son Ian, or herself as his carer, in the period between his first referral to the social services department and his death.
7. The Ombudsman considered these omissions to be maladministration.

What happened

2. Ian was assessed as requiring a course of counselling to assist his rehabilitation from alcohol addiction. The council identified and agreed to fund a course at a home in the area of another council.
3. Ian discharged himself early from the course, and died shortly afterwards of a drug overdose. The care home did not tell the council that he had discharged himself.
4. Mrs Rose complained that the council did not fully investigate the credentials of the care home. Mrs Rose said that Ian's care while at the home and his aftercare plan were inadequate, and that his spending of a social fund grant of £700 was unsupervised. She said that the family's complaint about what happened was not properly investigated.
8. The social worker's knowledge of the home was accordingly limited to what he observed during the visit, made by appointment, to allow Ian to decide whether to attend the course and the home to assess him as a suitable client. The social worker's judgement might have been clouded by his belief that the council had used the home before. He was not aware of critical reports made by the registration authority's inspectors about the home, or the notices served on the home the previous year requiring an increase in staffing levels and an improvement in the diet of residents.
9. The Ombudsman considered that proper enquiries would have indicated that the requirements of the notices had been met, and on balance it was not likely that a different decision would have been made.

Contract arrangements

Consideration of placement

5. The social worker visited the home with Ian, noted that the home had a current registration certificate and was satisfied with what he saw.
6. But the social worker did not make a proper check with the council for the area which was the registration authority for this care home. That was a contravention of the council's own policy. The social worker believed the home had been used previously by the council but no check was made to see if that assumption was correct.
10. Although the council had a financial contract with the home, there was no detailed specification which set out the expectations which the council had of the service provider. The home did not tell the social worker that Ian intended to leave the course prematurely. Aftercare arrangements were deficient. The Ombudsman said that the social worker should have been told of the discharge arrangements in advance and involved in formulating an aftercare plan.
11. The Ombudsman said that, if the council had entered into an appropriately detailed contract with the home, it might have been possible to prevent some of the faults which arose; in particular the contract should

have specified that the council should be notified in advance of discharge.

Complaints procedure

12. It appeared the council did not realise that representations from Mr and Mrs Rose could be treated as a formal complaint to be investigated under the statutory procedure, and the council did not tell them of their rights in this respect. The Ombudsman found that was also maladministration which caused further distress and frustration to them.

Outcome

13. The Ombudsman recognised that Ian was 21 years old and responsible

for his own decisions. Even if an adequate aftercare plan had been in place, and the spending of the loan had been properly supervised and money had been given to him in manageable portions, Ian might still have chosen to leave the home, obtained drugs and accidentally overdosed. The Ombudsman was unable to conclude that Ian's death would have been prevented if there had been no maladministration.

14. The Ombudsman recommended that the council should pay Mrs Rose £750 in recognition of the additional distress caused to herself and her family by its handling of their complaint.

(Report 98/C/2295)

J10: Residential care

Information for carers – fettering discretion – complaints procedure

1. Ms B complained about the way a council dealt with the care of an elderly lady, Mrs A. Mrs A had looked after Ms B when she was a child. Ms B complained that the council delayed in providing suitable residential care for Mrs A.

place. At the beginning of November 1995 Mrs A entered one of the residential homes suggested by the council and which charged a little more than £235 a week. Mrs A died there just before Christmas 1995.

What happened

2. Mrs A lived on her own for many years. By the time she was 98 she was finding it increasingly difficult to cope. In September 1994 Ms B went to see a residential care home (Home L) which might be suitable for Mrs A. There was no vacancy at the time.
3. In March 1995 the council decided that Mrs A met the criteria for placement in a residential home. In August 1995 Home L offered Mrs A a place.
4. Ms B asked the council to pay for Mrs A to go to Home L. But the place cost more than £235 a week, which was the council's standard rate, and so the council decided that Ms B would have to pay the difference. When Mrs A heard about this she refused to take the place.
5. Mrs A's health deteriorated and in September 1995 she was admitted to hospital. After some weeks the hospital considered that she no longer needed a hospital bed and could be discharged to a residential home. Ms B searched for suitable homes for Mrs A which charged at the council's standard rate. She could find none.
6. The council then decided that it was willing to pay up to £285 a week for a

Complaint

7. Ms B complained to the council about the way it had dealt with Mrs A's case. The council did not deal with the complaint under the statutory social services procedure until the omission was drawn to the council's attention by the Ombudsman. The council then arranged a hearing by a review panel.
8. Ms B was not satisfied by the council's response to the review panel's findings and so she complained to the Ombudsman.

Communication

9. The Ombudsman found a number of faults and considered that there were some general lessons to be learnt from the investigation. The first was about communication.
10. The Choice of Accommodation Directions 1992 provided guidance to local authorities about enabling people who needed residential accommodation to exercise a genuine choice over where they lived. The Ombudsman said it was important that councils should explain clearly to clients and their carers the implications of that guidance. That did not happen in this case.

Fettering discretion

11. The Ombudsman commented:

“Councils have a discretion to exceed the normal amount that they are willing to contribute to the cost of residential care and they should not fetter their discretion. In particular, they should have regard to the particular circumstances of each case.”

12. In this case, Mrs A was 99 by the time a place became available for her at Home L. She was frail and her health was deteriorating. She had visited some council-run residential homes and did not want to go into any of them and, even if she had been willing, there were no vacancies at the relevant time. Mrs A was willing to go into Home L and what led her to refuse the place initially was the thought that Ms B and her family would have to make a financial contribution.

13. The Ombudsman was not satisfied that the council properly considered the particular circumstances of Mrs A's case before declining to meet the cost of a place for her at Home L.

Finding a place

14. The Ombudsman said that councils should ensure that they do not place the onus of finding a suitable place at an acceptable cost on the client or the carers. When it became clear that Mrs A need not stay in hospital if a suitable place in a residential home could be found, the council should have dealt with the situation with greater urgency.

Residential cost

15. The Ombudsman commented:

“Where the charge for a place in one of their own homes is higher than the standard rate for a place in a private home, councils should be willing to explain the reason.”

Briefing note

16. An internal briefing note for the purposes of making responses to press enquiries contained inaccuracies and was misleading.

Complaints

17. The Ombudsman said that councils should be discerning in identifying which complaints should be dealt with under their own non-statutory complaints systems and which must be dealt with under the statutory social services complaints procedure. It was clear from other complaints that this council was not the only one which sometimes got this wrong.

Injustice

18. If the council had acted without fault, it was probable that Mrs A would have been placed in Home L or another suitable home far sooner than she was. That was an injustice to Mrs A. There was also injustice to Ms B. She was caused great anxiety about Mrs A's welfare and put to much avoidable time and trouble in searching for a suitable place. All this affected her professional life and her income.

Outcome

19. The Ombudsman commented:

“In cases of this kind, there is no ‘right’ figure for compensation. It is clear to me, however, that a payment should be made as a tangible recognition of the injustice to Ms B. I recommend that the council should pay her £2,000.”

20. The Ombudsman welcomed the reviews, which the council was undertaking, of its arrangements with a view to avoiding any repetition of the things that went wrong in this case.

(Report 97/A/3218)

J11: Residential care

Death of teenager in a council's care – assessment – care plan – complaints procedure

1. Mrs Hanson complained about the way a council discharged its responsibilities towards her son, Bruce, who had severe disabilities and who died while in the council's care. investigation and then consideration by a review panel. Consideration of the complaint spanned a period of some 18 months.

What happened

2. Bruce was born with a rare condition called Wolf Hirschorn syndrome. This resulted in him having severe learning difficulties, visual and auditory problems and epilepsy. He also suffered from malfunction of his digestive system, and he could not speak.
3. In his early teens Bruce became a resident at a children's home run by the council. Mrs Hanson said he was happy and well cared for there. As Bruce approached the stage for transfer from the care of children services to the care of adult services, the council assessed his needs and completed a care plan for him. The council arranged a move to a house managed by the social services department to accommodate clients with disabilities. Bruce was then aged 19.
4. Mrs Hanson was concerned about the standard of care provided at the house and the council became concerned that the house might not be suitable for him. The council reviewed the services provided for Bruce and began a reassessment of his needs.
5. One night Bruce became ill. In the morning his condition deteriorated and he was taken by ambulance to hospital. He died that day.
6. Mrs Hanson made a complaint to the council. There was an internal investigation, then an independent

Assessment process

7. A social worker drew up a document summarising Bruce's needs. This was discussed with Mr and Mrs Hanson at a meeting.
8. The Ombudsman considered that Mr and Mrs Hanson were not sufficiently brought into the preparation of this document. The Ombudsman considered it would have been better if they had been encouraged to read the medical assessments and respond in writing. They should also have been asked if they wanted to write down their own views. Although they saw the assessment document, they were not given a copy to keep.
9. The Ombudsman said that the council should have considered the appointment of an independent advocate for Bruce. That might have helped, not just with drawing up the document, but with the detailed interpretation of it when care arrangements were planned. Bruce's parents were able and willing to speak for him. But their role as parents was different from that of someone appointed specifically to represent the assessed person's interests.

Care planning

10. The Ombudsman found that there were inadequacies in the council's planning of the care package for Bruce. In particular:

- although various possible placements were considered, they were not talked through with Mr and Mrs Hanson;
- Mr and Mrs Hanson were shown a copy of the care plan but the council did not provide a copy for them to keep;
- the council did not live up to the expectations of its own guidance, or government guidance which required good records of the process of selecting from options and of the carers' involvement in that process – exclusion of Mr and Mrs Hanson from the stage of exploring options meant that they were under pressure to agree to what the council selected;
- the practicalities of implementing the selected option were not sufficiently thought through – in particular Bruce was known to be noisy at night and it was not sensible to put him in a semi-detached property;
- the council did not provide for a carer on the premises to be awake at night – that was contrary to the care plan, done without consultation with the parents, and distressing for Bruce; and
- there was inadequate support for the staff.

11. The Ombudsman concluded that Bruce should not have been moved to the new accommodation until a satisfactory system of care and support was in place, able to cope not only with his routine needs but also with the risks and contingencies to which he was vulnerable.

Care in the new placement

12. The Ombudsman said there was a significant degree of maladministration by the council in the care arrangements for Bruce at the new placement. For example:

- there was a failure to give adequate instruction to, and supervision of, agency staff;
- there were insufficient written records of Bruce's health;
- such records as the council did keep were not fully shared with Mr and Mrs Hanson;
- there was a failure to respond promptly and appropriately to a report by Mrs Hanson that Bruce had an abscess;
- there was no written instruction on the preparation of food for Bruce;
- Bruce's door was locked at night which seemed to be a measure of control rather than care; and
- there was no written policy on the locking of residents' doors.

The circumstances of Bruce's death

13. The Ombudsman noted that the review panel concluded that Bruce was unwell during the night and did not receive medical help. Night care staff had no proper briefing or induction on care for his unusual needs. Permanent staff sleeping in the home were not roused during the night and there was no evidence that they were fully briefed on taking over next morning. The Ombudsman saw no reason to dissent from those conclusions.

14. In the morning staff were concerned about Bruce. But they did not respond vigorously enough taking account of his vulnerability. Staff contacted a doctor but did not communicate any degree of urgency. It was more than two-and-a-half hours before the doctor came.

15. The doctor said he was reasonably confident that medical attention could

have saved Bruce if given early enough. It was possible, but not certain, that the delay in summoning urgent medical help cost Bruce his life. In any event, earlier attention would have spared him considerable pain.

Complaint

16. The Ombudsman considered that on the whole the review panel did a good job. But she expressed concern about a number of points, including:

- a senior officer who attended the hearing was a manager to whom the staff being questioned were answerable, so that his presence might have inhibited junior staff from saying all they wished (if staff were concerned about the hearing they could have called on personal support in the form of a friend or union representative); and
- the panel interviewed several members of staff at different levels of seniority simultaneously, and that gave rise to a risk of individuals, particularly junior officers, being inhibited from saying all they wanted to say.

17. The council accepted the panel's findings. But it was not clear to Mrs Hanson that her complaint had any effect. The council's response to her did not refer at all to the assessment and care planning process, where the independent person had

found the council wanting. Although the council's letter referred to an action plan for responding to the panel's recommendations, there was no specific information about what would be done. Nor was there any attempt to discuss ways in which the council could try to remedy the complaint for Mrs Hanson.

18. The Ombudsman pointed out that in a complaint which raised so many issues, the complainant should be told quite clearly which elements were upheld. If action was proposed to prevent recurrence, that action should be described and there should be follow-up information for the complainant after a reasonable interval.

Remedy

19. The Ombudsman recommended that the council should pay Mr and Mrs Hanson £10,000. The Ombudsman commented:

"This is not to be seen as compensation for the loss of their son. It is rather a way of recognising that failures by the council contributed to the distress occasioned by that loss. It is also to address the considerable time and trouble which they have been put to in pursuing the complaint and to enable them to draw a line under the sad events which led up to Bruce's death."

(Report 97/C/4618)