



Section K

Social services

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K1: Access to file

Enduring power of attorney – delay

Mrs Marlow complained that a council failed to allow her access to her husband's personal file held by the social services department.

Request

1. Mrs Marlow was concerned about aspects of the care provided for her husband and, in particular, the circumstances in which he had been transferred to a psychiatric hospital. She wrote to the council asking for access to the file.
2. The council asked Mrs Marlow to provide a copy of an enduring power of attorney. This is a legal document giving someone the right to act on behalf of another person.
3. Mrs Marlow took the document to the council. Some 18 months later access had still not been provided, and she complained to the Ombudsman.

4. It was 22 months after producing the necessary authority that she was finally able to see the file.

Delay

5. The Ombudsman pointed out that, allowing for consultation over third party consent which was required, she should have been able to see the file within 54 days of producing the enduring power of attorney.
6. The Ombudsman could find no justification for the council's delay in providing access.

Outcome

7. The council agreed to pay Mrs Marlow £200 by way of compensation for the delay.

(Report 00/C/18567)

K2: Admission to hospital

Compulsory admission – guidance for relatives

Mr A complained about the way a council arranged his compulsory admission to hospital.

What happened

1. Mr A suffered from an undiagnosed renal failure, which made his behaviour odd and extremely disturbing to his relatives. Mental health services were involved, and two doctors completed an assessment. They concluded that he seemed to be suffering from a mental illness sufficiently severe to warrant compulsory admission to hospital under the Mental Health Act 1983.
2. Following his admission to hospital, Mr A's renal failure was diagnosed and treated. No underlying mental illness was identified. Mr A later argued that the admission to hospital was inappropriate and unjustified.

The Ombudsman's view

3. The Ombudsman found that the approved social worker completed a proper assessment, including telephoning Mr A's mother, before Mr A was removed to hospital accompanied by two elderly relatives. But the Ombudsman was concerned that the council did not provide the relatives with written information that they could read and reflect upon after the dramatic circumstances of the admission. Such information could have explained the rights of the nearest relative to take action to secure a person's release from a compulsory admission if they considered that admission unjustified.

Information booklet

4. In response to the complaint the council produced an excellent booklet to be given to relatives in such circumstances. The booklet:
 - explained the assessment and admission procedures;
 - set out the roles and responsibility of key professionals and the rights of patients and their relatives;
 - summarised key sections of the Act in an accessible format;
 - identified organisations in the council's area which could advise and assist; and
 - set out the procedures for appealing and complaining about an admission under the Mental Health Act.
5. The Ombudsman considered that other councils could greatly assist patients, their relatives and carers, by producing similar information booklets.

(Complaint 99/B/5627)

K3: Care for adults

Temporary carers – failure to discover man’s death – complaints procedure

Mrs Ash complained about the actions of a council at the time of her father’s death, and the way the council dealt with her complaint.

What happened

1. Mrs Ash’s father, Mr Oak, was discharged from hospital and went to live with his son, who acted as his carer.
2. The council agreed that, while the son was abroad for two weeks, it would arrange for Mr Oak to be visited once a day. The visits were to be undertaken by one home care assistant at weekends and a different home care assistant on weekdays.
3. One morning a home care assistant called at the house, Mr Oak did not reply, and the home care assistant went away and returned later. While she was away, Mrs Ash’s daughter and 12 year old grandson discovered Mr Oak’s dead body by his kitchen window.
4. The Ombudsman’s investigation established that the home care assistant had not noticed two pints of milk by the door, and had not looked through the kitchen window.
5. Also, the home care assistant was not told by her manager that the other home care assistant had found Mr Oak collapsed on the floor just two days earlier. That was vital information which would probably have affected the way the home care assistant acted when Mr Oak did not reply to her call.

Complaints procedure

6. The Ombudsman said that the council’s handling of Mrs Ash’s complaint was lamentable. The council’s leaflet for

members of the public included four undertakings:

- that a senior manager would arrange a meeting with the complainant as a first step;
 - that the complainant would receive a letter from the manager explaining the outcome of the complaint within 28 days;
 - if there were likely to be delays, the manager would seek the complainant’s agreement and keep him or her informed of progress; and
 - that the letter would explain what to do if the complainant was not happy.
7. Not one of the published promises was honoured. That was maladministration.
 8. Failings identified by the Ombudsman included:
 - not treating the first stage as the process it was meant to be – a quick informal effort to resolve the complaint (in fact it was six months before the response at stage one was given);
 - failure to give a proper briefing to the investigating officer (who was dealing with her first complaint) and remind her of key points;
 - failure of the investigating officer to make notes of relevant actions and conversations, failure to amend her report in the light of corrections suggested by Mrs Ash, and loss of the file; and
 - failure of managers to provide support and monitoring for the investigating officer.

9. The Ombudsman commented:

"It was a serious error not to keep a close and helpful watch on someone dealing with her first complaint."

Injustice

10. The Ombudsman accepted that it was not possible to say whether or not Mr Oak was alive when the home care assistant visited. But it was clear that she would not have walked away if she had been properly briefed. The failure to communicate the previous incident to her was serious maladministration. The Ombudsman was concerned that the passing on of such information appeared to be a hit and miss affair.

11. It was not possible to say everything that might have happened without the maladministration. But at least Mrs Ash's grandson would have been spared a traumatic experience.

Outcome

12. The council agreed to pay Mrs Ash £300 compensation and also agreed:

- to review how important new information about clients was passed between home care assistants and their managers;
- to ensure that all officers who were likely to have to deal with social services complaints were properly briefed about procedures; and
- to ensure that officers dealing with such complaints received adequate monitoring, support and training.

(Report 00/C/14156)

K4: Care for adults

Consultation over choice of nursing home – information needed by home – complaints procedure

Mr West complained about events relating to the care his grandmother received in a nursing home chosen by a council.

What happened

1. Mr West's grandmother, Mrs East, was aged 101 at the time of the relevant events. She was admitted to a nursing home for a short period of respite to improve her mobility following an infection to her leg. She was in the nursing home for 10 days. She died three weeks later.

Choice of nursing home

2. The council did not consult Mrs East and Mr West on the choice of nursing home. The Ombudsman found that was maladministration.

Nursing home arrangements

3. The nursing home was contracted to the council to provide nursing care for people to whom the council owed a duty under the National Assistance Act 1948.
4. The Ombudsman found nothing to criticise in the council's overall arrangements for supervising the quality of care provided in homes with which it contracted. The first component of the council's duty to make proper arrangements for the residential accommodation of those to whom it owed a duty was thereby satisfied. The home was one that in general met the council's reasonable contractual arrangements.

5. However, the Ombudsman was critical of the particular arrangements made for the admission of Mrs East. He did not believe these were sufficient for the council to satisfy itself that she as an individual would receive the care she needed. There was no evidence that the key document setting down Mrs East's care needs – her care plan – was given by the care manager to the home. And her admission was not accompanied by any other documentation from the council specifying to the home just what was expected of the care she should receive.

6. The Ombudsman observed that the care plan was an important document, drawing special attention to significant issues of feeding, washing and medication. It was maladministration for the council not to give the home a copy of the care plan.

Complaints procedure

7. Mr West was unhappy about the care provided in the nursing home for his grandmother. The Ombudsman recognised that there were important issues of medical care which were the responsibility of health professionals and the health authority. But none of them indicated any failure of the administrative functions of the council. However, the Ombudsman was critical of the way in which the council dealt with Mr West's complaint under the statutory social services complaints procedure.
8. In particular, the Ombudsman was concerned that:
 - the council took over two-and-a-half months to deal with the complaint at stage one of the procedure, rather than the expected 14 days;

- the council's response was less than complete and, while it accepted that some errors had been made, it did not offer an apology;
- the written decision of the review panel at stage three was inadequately expressed and reasoned, and no explanation was given of what the council's irregularities and shortcomings were;
- only when the chairman of the panel was interviewed by the Ombudsman's investigator did it become apparent why the panel had reached the conclusions it did on each separate complaint; and
- Mr West was told that the director of social services would write to him after considering the panel's decision, but the director did not do so.

Injustice

9. The Ombudsman said it was not possible to know whether the failings had any impact on the care Mrs East received at the home. But Mr West had the uncertainty of not knowing whether the care might have been better, and was put to a lot of trouble in pursuing his complaint.

Outcome

10. The Ombudsman recommended that the council should make a payment of £1,500 to Mr West. Also that the council should:
 - put in place procedures to ensure that in future there would be no failure to consult residents and their carers about the choice of nursing or residential home;
 - ensure that, at the time of an admission to a nursing home, the existing care plan was passed on to the management of the home; and
 - review its training procedures for staff and members involved in the operation of the social services complaints procedure.

(Report 99/B/3078)

K5: Care for adults

Agency cover – withdrawal of service – fettering of discretion by the council

Mr Trent complained about the withdrawal of a home care service for his father.

mileage over and above the flat rate fee to carers.

What happened

1. Mr Trent's father, Mr Derwent, was 90 years old and suffered from Parkinson's disease. Mrs Derwent was 92 years old, blind and suffered with angina.
2. The council assessed Mr Derwent as needing help getting up and going to bed. Assistance for weekday mornings was provided by the council. Assistance for evenings and for weekends was provided by an agency acting on behalf of the council.
3. On 1 February 1999 the agency informed the council that it was withdrawing from the provision of the weekend service because it could not recruit staff. On 2 March the council informed Mr and Mrs Derwent of this and said that the district nurse would provide interim cover while the council tried to find an agency to resume the putting to bed service. The council explained that, if it could not find alternative carers, Mr Derwent would be offered respite care at weekends at a residential home.
4. The agency gave notice to the council that it would withdraw the evening service from 26 March.
5. The council contacted all the agencies which had contracts to provide care on behalf of the council to see if any was able to provide the service required. Only one agency said that it might be prepared to provide staff, but it asked that the council should pay the mileage costs of the staff attending. The council declined to do this on the grounds that it was not the council's policy to pay

6. On 24 March Mrs Derwent was admitted to hospital. On 26 March Mr Derwent went for respite care to the residential home. He was admitted to hospital from there and died on 21 April.
7. The council explained that it did not agree to pay mileage as this would have set a precedent. In the council's view it would have been damaging to stable contracting arrangements if the council agreed to pay enhanced rates if an individual firm withdrew from a contract.

The Ombudsman's view

8. The Ombudsman said that home care provided for vulnerable older people was among the most important and sensitive of all the services provided by the council. The service for Mr and Mrs Derwent fell far short of acceptable standards.
9. The Ombudsman recognised that it might not be easy to arrange for home care in the rural parts of the council's area, and even the best contractual agreements must fail from time to time. But when a service failure occurred, the Ombudsman said, the council could well have to seize any realistic opportunity to make the service good. Here it had such an opportunity.
10. It seemed to the Ombudsman that Mr Derwent's home care was entirely sacrificed to maintain the purity of the council's contractual arrangements. No one seriously thought of making him an exception to policy, even though the cost of the weekend respite care was likely to outweigh by far the travel costs of agency staff. The Ombudsman commented:

“The council – for reasons of policy – put such an exception entirely out of its mind. This was a classic case of the council fettering its discretion, and was maladministration.”

Outcome

11. The Ombudsman said that Mr Trent and the family had to live with the pain of knowing that this problem overshadowed to some extent their parents’ last days together. He recommended that the council should:

- make Mr Trent an *ex gratia* payment of £500; and
- put in place arrangements to ensure, as far as possible, that the maladministration identified did not recur.

(Report 99/B/799)

K6: Child protection

Registered child minders – allegations of abuse – flaws and delays in investigation

Mr and Mrs Pontefract complained that they were unfairly treated by a council during its investigations of allegations of child abuse made against them as child minders.

Faults

1. The Ombudsman found a number of faults:
 - the couple were given the impression that their registration had been suspended when that was not the case;
 - neither of the officers who visited the Pontefracts was fully prepared for the task involved, and one was unaware of the law on suspension of child minding registration;
 - the council delayed unreasonably by about three months in giving the couple details of the allegations against them;
 - the officer who undertook the initial investigation was unaware of council guidelines that an investigation should be completed within 15 days, and the investigation in fact took 15 weeks; and
 - there were flaws in the investigation, with no files being examined, information being missed and a relevant discussion with a social worker not being undertaken.

Injustice

2. The Ombudsman considered that the maladministration by the council resulted in the loss of seven months' earnings for the couple.

Outcome

3. The council agreed to pay Mr and Mrs Pontefract £7,000.
4. The Ombudsman commented:

"I trust that the council will ensure that the delays which arose in this case will not be repeated and that relevant staff are made aware of the council's powers in relation to child minders. In particular, I am concerned that staff who may be called upon to make visits to child minders and foster carers in the sort of situation which arose in this case should be properly trained for the task."

(Report 00/A/9653)

K7: Child protection

Complaints procedure – response by council inadequate – failure to provide clear and accurate information

Mr and Mrs Bowen complained that a council did not properly respond to their complaints or respond adequately to their concerns about the welfare of their grandson.

Their grandson lived with his mother, who was their former daughter-in-law. Mr and Mrs Bowen did not believe that their concerns were taken seriously and thought the social worker concerned was accepting uncritically their former daughter-in-law's explanations for their grandson's distress.

Complaints procedure

1. Mr and Mrs Bowen made a formal complaint to the council under the statutory complaints procedure.
2. The Ombudsman found that there were deficiencies in the investigation report. That led Mr and Mrs Bowen to believe that the council was seeking to cover up some of its mistakes. The Ombudsman thought that was partly the result of failure to agree the terms of the complaint at the outset.
3. The Ombudsman said she would not criticise the decision to seek to address the major issues and to refer to the more minor issues as evidence. However, that should have been done with Mr and Mrs Bowen's agreement. They would then have had the opportunity at an early stage to stress the significance to them of particular issues.
4. The Ombudsman found that the responses from the assistant director following receipt of the report, and of the director following the review panel's findings, were both inadequate. They failed to address the criticisms made and to identify action to be taken.
5. In the case of the assistant director's response, the preparation of an action plan some months after it had been promised, with a false claim that it had been in existence some months earlier, was a clear attempt to cover up an omission and was inexcusable.
6. Neither the panel nor the director offered any remedy to Mr and Mrs Bowen for their time and trouble in pursuing the complaint or for the injustice suffered as a result of those parts of the complaint which were upheld. Despite promises of improved communication, they were not receiving minutes of meetings promptly. The Ombudsman said that a six-month delay in circulating minutes of a meeting was unacceptable.
7. The Ombudsman also criticised the failure to give Mr and Mrs Bowen clear and accurate information about the process of assessment of their concerns. That contributed to their loss of confidence in the process and the judgement of those carrying out the assessment. That was further eroded by inaccuracies in the assessment report which were not corrected until long after they were first raised by Mr and Mrs Bowen.

Injustice

8. The Ombudsman said that Mr and Mrs Bowen had had to take a considerable amount of time and trouble in seeking explanations and responses to their complaints. They had understandably been left feeling that they had not been treated with respect and that their views were ignored.

Outcome

9. The council agreed to pay compensation of £500 to Mr and Mrs Bowen.
10. The council also agreed to improve procedures by:
 - issuing clear instructions to staff on the timescales for circulating minutes and care plans;
 - issuing advice to staff responsible for preparing reports for courts about checking the contents of those reports and, where information was not verifiable, making clear the source of the information; and
 - advising officers responsible for investigating complaints that, at an early stage in the process, they should agree a statement of complaint with the person making the complaint.

(Report 00/C/4462)

K8: Day care

Charging policy – information and criteria – no reasons given for decisions – complaints procedure

Mrs Cullingford and Mrs Bell complained on behalf of their son and daughter respectively about the way a council introduced a new charging policy and the way it dealt with their applications to have charges waived.

Circumstances

1. Mrs Cullingford's son and Mrs Bell's daughter were both people with severe disabilities who had extensive care needs. They were both in receipt of the higher rate of disability living allowance. They attended day centres several times a week.
2. The council decided to introduce higher charges for domiciliary care and day care attendance. The effect for Mrs Cullingford's son, for example, was that the weekly charges would increase from £9.75 to £21.50.
3. The council's new charging policy included provision for a review of charges if representations were made by service users. Both Mrs Cullingford and Mrs Bell applied for charges to be reduced or waived. They were both unsuccessful.

The Ombudsman's view

4. The Ombudsman was concerned about a number of points.
5. The thrust of the legislation and the available advice was that service users should be given a reasonable opportunity to make a case that it was not reasonably practicable for them to pay charges for day care. The advice also suggested that there was a duty upon councils to inform all users of the possibility of charges being waived or reduced. In any event, that would be

good practice. The Ombudsman said that the implication of all this advice is that all efforts must be made to give those who do not find it easy to meet the charges a full opportunity to make their case and to have it considered sympathetically and fairly. She commented:

"The procedure used should be simple to follow and understand, and should be transparent. Clear reasons for decisions should be given."

6. There was no adequate information available about how to apply for charges to be waived at the time when applications were made. The criteria for assessing any such applications were not approved until several months after the introduction of the new arrangements. The Ombudsman pointed out that the new charges could account for as much as a quarter of a service user's disability living allowance and the council must have been aware of the potential this could have for creating anxiety. The effect of the lack of information was that people applying for charges to be abated had no idea of the factors which would support their case or should be taken into account.
7. Even when the criteria were established, they were not widely publicised to people who might have difficulty paying the charges.
8. The council's approach was to ask those asking for a reduction to demonstrate financial hardship. That was not the test set down by the legislation. The council's approach pitched the threshold too high, thereby rendering the policy unreasonable and possibly unlawful.
9. No reasons were given to unsuccessful applicants as to why their applications

had failed. So they had no way of challenging the decision, or providing additional information which might affect it.

10. The council made no provision for any appeal. Both Mrs Cullingford and Mrs Bell made complaints under the statutory complaints procedure. In the case of Mrs Cullingford, the Ombudsman had a number of concerns. The first was that the council did not initially allow her to access the statutory procedure. It took eight months before she was able to proceed with the complaint. Even at the time of the Ombudsman's report, Mrs Cullingford had still not received a letter confirming how the council would respond to the review panel's findings, although that had been promised in a letter nine months earlier.

11. The Ombudsman commented:

"In my view, a process which should have taken perhaps weeks, has dragged on for years. This does seem to me to be a consequence of the council's failure to establish proper procedures for dealing with these issues from the outset."

12. The Ombudsman commented that both complainants were left to flounder with their applications for the charges to be waived in a manner which seemed to be contrary to the spirit of the legislation. They both already had stressful lives. In the Ombudsman's view the council's procedures did nothing to alleviate that.

Outcome

13. The council agreed to:

- establish a proper procedure for dealing with claims for charges to be waived, including a test for judging whether or not payment was reasonably practicable, along with proper criteria and a procedure for investigating claims;
- inform all service users that there was a possibility of having charges waived and explain the criteria against which such applications would be assessed;
- provide help where necessary for service users to formulate an application for fees to be reduced;
- undertake to provide full reasons for each decision made;
- allow a formal appeal against a decision not to waive fees, to be heard by someone different from the person who made the original decision; and
- allow anyone aggrieved by a decision, whether the merits of the decision or the process or both, to have access to the statutory complaints procedure.

14. Once that new procedure had been established, Mrs Cullingford and Mrs Bell would be given the opportunity of having their cases considered once more. They would also each receive £500 in recognition of the delay, stress and anxiety they had been caused.

(Report 99/C/2509 et al)

K9: Residential care

Legal charge on house – need for families to have full information about finance so that properly informed decisions can be made

Mr Berry complained that a council did not properly inform him about the financial arrangements when his mother moved to a residential care home.

What happened

1. Mr Berry lived with his mother and had done so for many years. He said that he understood from a council officer that the value of the house, which was owned by his mother, would not be taken into account when the council calculated her contribution towards the cost of residential care.
2. Mr Berry said that, if he had been told that the value of the house would be taken into account, he would have given up his job to care for his mother at home. He said the council failed to advise him, until four-and-a-half months after his mother had gone into residential care, that the value of the house would be taken into account. As a result, the council had a legal charge on the property. Mr Berry's mother died and he inherited the property.

The Ombudsman's view

3. The Ombudsman was not satisfied that the council officer did tell Mr Berry that the house would be disregarded. But the officer was not as clear in her statements as she should have been under the circumstances. Mr Berry had made it clear to the council that it was important to him that any financial assessment should exclude the house.

4. The Ombudsman commented:

"Those in the position of Mrs Berry and Mr Berry should be given clear written advice of the financial consequences of an admission into residential care so that informed decisions can be taken by everyone involved."

5. The Ombudsman also said that financial assessment should be done very much more quickly than was the case here.

Outcome

6. The Ombudsman accepted that Mr Berry would have given up his job to care for his mother if he had been properly informed by the council.
7. The council agreed to waive over £2,000 from the amount originally sought, and agreed to waive the interest on the charge. The council also said that it would never seek to make Mr Berry homeless.
8. The Ombudsman did not ask the council to lift the charge itself as Mrs Berry did have the benefit of the residential care, the cost of which was properly recoverable. In all the circumstances, the Ombudsman considered the council's actions provided a satisfactory outcome to the complaint.

(Report 98/C/4738)

K10: Residential care

Adult with severe disability – parents in poor health – council assessment confirms need for residential care – council refuses to arrange placement on grounds of budgetary difficulties

Mrs Cooper complained about the way a council dealt with her sister's needs. The council decided that her sister needed residential care, but then refused to provide the service, citing shortage of resources.

What happened

1. Mrs Cooper's sister, Miss Bryan, had a severe learning disability. She had lived all her life with her parents or other relatives.
2. In February 1998 the council carried out an assessment and found that Miss Bryan needed assistance with medication, diet, preparation of meals and drinks, personal hygiene, communication, household tasks, shopping and the use of money, getting out of bed, and going anywhere outside the house. At that time, Mr and Mrs Bryan were coping with their daughter's care but were worried about the future.
3. By the summer of 1998, Mr and Mrs Bryan found it increasingly difficult to cope with Miss Bryan's care because of their own failing health. The council assessed Miss Bryan's need for residential accommodation, and that assessment was completed in August. The council concluded that Miss Bryan needed a residential placement. A care co-ordinator attempted to find a suitable home for Miss Bryan. But in March 1999 the council wrote to Mrs Cooper to tell her that it could not at that time finance a residential care package for her sister. Mr and Mrs Bryan's GP expressed concern to the council about their failing health and about Miss Bryan's situation. In September, Mrs Cooper's solicitor also approached the council. The council continued to say that it could not forecast when funding might become available.
4. It was not until November 1999 that the council agreed to provide funding, and Miss Bryan was offered a suitable placement.

Legal background

5. The Ombudsman pointed out that the courts had ruled that, once a council had assessed someone as being in need of residential accommodation, the council was not entitled to say that, because of its lack of resources, it was not prepared to meet its duty to that person.

Outcome

6. The council accepted that the delay in providing residential care was unacceptable. The Ombudsman commended the council for taking that view.
7. The Ombudsman said the council's fault caused considerable injustice. Miss Bryan was forced to live in conditions that the council assessed as utterly unsuitable for 11 months longer than she should have done. Her parents also suffered injustice. They suffered considerable strain, anxiety and distress from having to care for Miss Bryan in conditions that they knew were unsuitable for her needs, and when they were not themselves able to cope with the demands put upon them. Mrs Cooper was put to considerable time and trouble in pursuing her complaint with the council and with the Ombudsman.
8. The Ombudsman was pleased to note the measures the council was taking through a review of its assessment arrangements and budgetary provision. The council said that no adults with

learning disabilities should in future be in the position of facing the long delay experienced by Miss Bryan.

Remedy

9. The council agreed to pay Miss Bryan £2,000, Mr and Mrs Bryan £2,000 and Mrs Cooper £250.

10. The council also agreed to take steps to identify other people who might have been similarly affected, and to offer a similar remedy where appropriate.

(Report 99/B/4621)