



Section J

Social services

J1-2	Adaptations	92
J3	Adoption	95
J4-6	Care services	97
J7	Child protection	102
J8-10	Residential care	103

J1: Adaptations

Tenants with disabilities – delay – review of arrangements

Mr Wren complained on behalf of three citizens about delays by a council in adapting their homes.

Difficulties

1. All three had physical disabilities which made it difficult for them to use a bath or to get up stairs.
2. All three lived in properties owned by the district council. The county council had powers and duties to ensure that the needs of disabled people were met in their homes, though that was not of direct relevance. The district council took sole responsibility for providing adaptations in its own properties. If the county council had been directly involved there would have been a clear legal duty to provide the adaptations.

Delays

3. In two cases the provision of facilities took some two years longer than the Ombudsman thought was reasonable. In the third case the delay had been for one-and-a-half years at the time of the Ombudsman's report, with no sign of a solution.
4. The council explained that it had more than 300 outstanding requests for adaptations and a limited budget. The Ombudsman did not accept that a lack

of resources was an acceptable reason for excessive delays in helping people whose needs had been clearly assessed and accepted. The district council had to shoulder the blame for the fact that what was effectively a legal duty was not met.

Injustice

5. The Ombudsman said the problems suffered by the three complainants were by no means negligible. The inability to manage bathing and washing properly was a significant injustice.
6. The Ombudsman recommended compensation of £1,200 in the two cases where work was completed and commensurate compensation in the other case to cover the period until a reasonable solution was provided.
7. The Ombudsman was pleased to note that the council had reviewed its arrangements and was taking action to deal with the backlog of requests.

(Report 02/C/8679 et al)

J2: Adaptations

Mobility difficulties – level access shower needed – whether budgetary difficulties can be taken into account – liaison between councils

Mr Lucas complained that a county council and a borough council failed to assess him for, and provide him with, a level access shower.

What happened

1. Following a stroke, Mr Lucas had greatly reduced mobility, and could walk only by shuffling with the aid of a zimmer frame.
2. The county council assessed his needs. Mr Lucas lived in a bungalow owned by the borough council. It had a shower but this had a step up to it and Mr Lucas could not access the shower. He asked for a level access shower. Following a report from an occupational therapist, the county council agreed to support his request and made the recommendation to the borough council.
3. The borough council failed to recognise that the referral from the county council was made under the Chronically Sick and Disabled Persons Act 1970. In addition, the borough council misinterpreted the law and thought it could take budgetary difficulties into account when asked to provide adaptations which had been accepted as being needed under this legislation.
4. The county council failed to liaise properly with the borough council and, in particular, had not indicated the level of priority that should be given to referrals following an assessment by an occupational therapist.
5. There was a delay of 18 months before Mr Lucas was provided with the shower which the assessment had determined that he needed.

Criteria

6. At first the county council had told Mr Lucas that he did not meet its criteria for the installation of a level access shower. The Ombudsman said the question arose as to whether the council's criteria were unreasonable. She said that it would be unreasonable to set criteria so tightly that people obviously in need did not qualify. On the face of it, Mr Lucas had such a need.
7. The county council exercised discretion by making a referral nonetheless, and there was no injustice to Mr Lucas. However, the Ombudsman welcomed the county council's undertaking to review the criteria.

Budget

8. The Ombudsman pointed out that there was a requirement to meet assessed need without unreasonable delay. The borough council's response that provision had to wait because of budgetary difficulties was unacceptable. The council's interpretation of government guidance and case law was misinformed. That was maladministration.

Liaison

9. The county council did not prioritise its referral to the borough council. The borough council said this created a difficulty and the Ombudsman sympathised with that point. Even in the best of circumstances and no budgetary constraints, it was clear that not all works could always be completed at once. Therefore in order best to meet the

greatest need without undue delay, a system of prioritising referrals was necessary. The absence of such a system was maladministration. The Ombudsman commented:

“Where, as in this case, more than one authority is responsible for delivering a service, an agreed protocol and a system of liaison is necessary. The ad hoc system here, which broke down with the absence of an individual officer, is inadequate...The absence of such a protocol and system of liaison is maladministration by the authorities jointly.”

Outcome

10. Both councils agreed that Mr Lucas had not received the service to which he was entitled. They accepted the Ombudsman’s recommendation to make a payment of £1,000 to Mr Lucas, with half of the amount being met by each council. The Ombudsman commended the councils for their positive response.
11. The county council undertook to review its working arrangements with all the district and borough councils in the county. The Ombudsman welcomed that initiative.

(Report 02/C/4897 and 02/C/13783)

J3: Adoption

Allegation that applicant was abusive – no written records – allegation not specific

Ms Baker complained about the actions of a council in connection with her application to adopt a child.

“This is a sad story. A family preparing itself to welcome another child had the opportunity taken from it and a never-to-be identified child somewhere may have lost the opportunity to become part of that family.”

What happened

1. Ms Baker was the mother of two adopted children. She applied to the council to adopt a third child.
2. The application ran into difficulty and finally proved abortive. This was because the council accused Ms Baker of being rude and abusive to two council officers.
3. The complaint had its roots in the cancellation at short notice of a meeting between Ms Baker and council officers. Ms Baker had been waiting many months for what she anticipated being a vital meeting in connection with her adoption application. She felt that she was treated discourteously and received no apology for the cancellation of the meeting. A council officer then made a complaint that Ms Baker had been rude and abusive in a telephone conversation. Ms Baker was not told what it was that she was accused of saying but she was told that unless she apologised her application to adopt a child would not be considered.
4. The council took a year to investigate Ms Baker’s complaint.
6. The planned meeting with Ms Baker was called off because a social worker had to attend court and none of her colleagues could deputise. The Ombudsman agreed that the council had no option but to rearrange the meeting with Ms Baker and made no criticism of that action.
7. The Ombudsman said that, in the circumstances, the council had an immediate duty to contact Ms Baker and offer her an apology for the difficult position in which it found itself. It owed her an explanation too. It could then have set about the task of organising another date as soon as possible at a time convenient to her and the council.
8. The Ombudsman found that it was not the adoption unit’s practice to keep a note of telephone calls. The Ombudsman considered that the failure of the officer to record a material call such as this one, and one which was to form the basis of a complaint against a member of the public, was maladministration. The point was even more pertinent because the officer was about to leave and other officers would need to take the matter forward.

What the Ombudsman found

5. The council had more children who needed adoption than families able to adopt. The Ombudsman commented about Ms Baker’s complaint:
 9. The Ombudsman said the complaint should have been put to Ms Baker in writing. Ms Baker would then have had the opportunity to comment to the council on the basis of knowing what the council was concerned about. The

council could then have considered the matter properly. Failure by the council to put squarely to Ms Baker what she was alleged to have said was maladministration.

10. Ms Baker was told that, unless she apologised, her application to adopt could not proceed. The Ombudsman agreed that the unit manager had a duty to support his staff. But there was an issue of proportionality. Withdrawal of an application to adopt was a harsh and wholly disproportionate response.

- agreed to review its procedures in order to include complaints from adopters and potential adopters within the statutory social services complaints procedure; and
- agreed to review its policy for recording personal and telephone contact with the public where conduct of any person could lead to some action being taken against them or to the withdrawal of a service.

Outcome

11. The council:

- offered an immediate apology to Ms Baker and agreed to pay her £1,000 compensation;

(Report 02/C/16768)

J4: Care services

Care assessment – care package – direct payment scheme – complaints procedure

Mr Norton complained about a council's failures relating to his adult daughter Louise's care needs and care provision.

What happened

1. Louise had spastic diplegia and was registered blind. She needed 24-hour care and support.
2. When she left her residential special school, Louise moved to a specialist residential care home. This was a long distance away from the family home.
3. Louise expressed unhappiness with her placement and a desire to live at home. The council carried out an assessment but did not produce a care plan or provide care services. Mr Norton arranged care at his own expense for some two-and-a-half years.

Statutory complaints procedure

4. The majority of Mr Norton's complaints to the council were upheld, either as part of the council's investigation or by the review panel. Assessment procedures had not been followed properly and the council failed to provide a proper care package. The council agreed to review and improve its procedures. In response to Mr Norton's request for compensation, the council said that he should seek legal advice with a view to taking legal proceedings. Mr Norton complained to the Ombudsman that the council had failed to provide a tangible remedy for the injustice he and Louise had suffered.

The Ombudsman's view

5. The Ombudsman said that Louise was entitled to decide that she wished to live near her family and be cared for at home. The council had an obligation to reassess her needs and the care services it was providing, taking into account her preferences. The council had a duty to produce a care plan. That should have been in place at the latest three months after Louise returned home. The absence of such a plan and the care services which would have been provided as a result amounted to maladministration.
6. The Ombudsman noted that part of Mr Norton's complaint which was not upheld by the council was about the initial decision that Louise was not eligible to benefit from the direct payment scheme the council had produced. That was a scheme to provide direct payments to service users to pay for their care. Government guidance on the application of a direct payment scheme was that service users should be willing and able (alone or with assistance) to administer payments. The council's scheme took no account of the guidance in brackets and the council only considered whether direct payments could have been managed by Louise alone, and did not consider whether she could do so with the assistance of someone else. The council provided no information to Mr Norton about how he could challenge its decision.

Injustice

7. The Ombudsman considered that Mr Norton had been caused significant financial loss, distress, and frustration from having to manage without the council's support in care provision for a long period. The information Mr Norton provided showed that he might have lost in the region of £70,000 through having to provide for his daughter's care when the council did not do so.

Remedy

8. The council agreed to the Ombudsman's recommendation that it pay Mr Norton £80,000.

(Report 01/B/9360)

J5: Care services

Home care package – cultural needs – delay

Mr A complained that a council delayed in implementing a culturally appropriate care package for his father-in-law, Mr B, and that it acted unreasonably by refusing to reimburse the costs incurred when a suitable care package was not provided.

What happened

1. Mr B suffered a severe stroke. Following a long stay in hospital, he returned home with a care package provided by the council.
2. After some two years the council felt that Mr B's needs would be better met within a residential care setting. But the family were not happy about the proposal that Mr B should be cared for outside the home. Their culture required that Mr B should remain at home with the family. Mr A also explained to the Ombudsman that it was important that carers should be able to communicate with Mr B in his own language. He was a Vietnamese speaker.
3. An interim care arrangement provided by the council broke down within a few days. This was because of Mr B's aggressive behaviour towards the carers who could not speak his language.

Delay

4. A satisfactory care package was put in place eventually. But the Ombudsman considered that the time taken to put the package in place was unreasonable.

The review panel under the social services statutory complaints procedure identified delay. The reasons for that included a delay in the case being passed from the disabilities team to the older persons team in accordance with the council's standard arrangements; a failure to allocate his case immediately to a social worker; and time spent in putting together a care package which was appropriate for Mr B's needs.

5. Mr A employed private carers for a significant period.

Outcome

6. At the Ombudsman's suggestion, the council agreed to pay Mr A compensation equivalent to the amount that it would have cost to provide care for a period of some eight months. That amounted to £17,426.

(Local settlement 01/B/17685)

J6: Care services

Mental health problems – care after discharge from hospital

Mr Jones and his adopted son complained about the way a council dealt with the latter's needs. The younger Mr Jones had mental health problems.

The complaint

1. Mr Jones and his son complained that there was no recognition by the council that the younger Mr Jones was ill and required care in the community after he stopped work as a result of mental illness, and that there was insufficient liaison by the council's mental health team with him and his adoptive parents, who were his carers.
2. They also complained that there was no assessment of the community care needs of the younger Mr Jones, or the needs of his carers, for periods when he was out of hospital and living in the community.
3. Mr Jones Senior believed that, if the council had provided appropriate community care to his son following discharge from hospital, it might have been possible for his son to make a better recovery and to deal more confidently and calmly with issues relating to his children. There were legal proceedings in train concerning the future of the children and their possible adoption.

What the Ombudsman found

4. The Ombudsman found that the council did not properly assess the community care needs of the younger Mr Jones and those of his carers. The Ombudsman also criticised the council's failure to communicate clearly to Mr Jones and his parents its role and responsibilities towards them. The mental health social worker failed to keep adequate case

notes. The council had decided to give low priority to attendance at certain meetings to discuss Mr Jones' release from hospital on home leave, and to plan for permanent discharge.

5. The Ombudsman considered that the council should have ensured that, well before the son's release from hospital, a support network was set up and properly funded, and that those in the network had the opportunity to get to know Mr Jones in hospital so as to be familiar figures to him when he was released.
6. A social worker said there was no formal assessment of Mr Jones' care needs and, because he would not agree to talk to her, she saw no realistic chance of his accepting help. However, the council did not write to Mr Jones or his parents explaining the range of help the council could offer. The council accepted that, once it had satisfied itself that Mr Jones was resistant to social work help, it could and should have written to him confirming the situation and warning him that the council could not fulfil its statutory duties to conduct an assessment without his co-operation. The council also accepted that it could have written to Mr and Mrs Jones Senior in the same manner.
7. The Ombudsman said that in addition to practical domestic help, the council could have considered providing someone to help Mr Jones explore activities in the community and find out how to obtain new skills, and perhaps be a friend or advocate to help him with correspondence and other domestic affairs. The failure to explore with Mr Jones prior to discharge just what support could reasonably be provided was maladministration.

8. The Ombudsman commented:

“This complaint raises issues about a vital area of public administration; planning for the care of those who are released into the community from mental hospital. The consequences of failures in aftercare have often been brought to public attention when a tragedy befalling the mentally ill person or others has occurred. Yet to avoid, as far as possible, those tragic consequences calls for careful pre-planning and managed support. In this case both were almost non-existent.”

9. The Ombudsman said that the council should have assessed Mr Jones’ needs as part of prior planning for his discharge. It should have aimed to help him resettle into the community and secure comprehensive support which might reduce the risk of relapse which could pose a threat to Mr Jones or others.

10. The Ombudsman accepted that it was possible that Mr Jones might not have co-operated with an assessment. But it seemed to the Ombudsman that the council should have tried harder to suggest the sorts of areas in which support could have been provided. It should also have put to him in writing that it was unable to proceed with such arrangements without his co-operation.

11. The Ombudsman also said it was maladministration that the council gave low priority to attendance at care planning meetings and failed to ensure that officers kept appropriate case notes.

Injustice

12. The Ombudsman thought that, if the council had done more to conduct assessments properly, it was possible that the younger Mr Jones might have

reacted more positively to the offers of support and practical assistance. It was not possible to say that his mental health had been adversely affected by the lack of proper support from the council, but the Ombudsman believed Mr Jones lost an opportunity which might have benefited his mental wellbeing. Also Mr and Mrs Jones Senior lost the opportunity of help in caring for their son, which could have relieved some of the pressure on them.

Outcome

13. The Ombudsman recommended that the council should:

- conduct as far as it could an assessment of Mr Jones’ community care needs and those of his carers prior to any future release from hospital;
- make a payment of £500 to Mr Jones and of £1,000 to Mr and Mrs Jones Senior; and
- carry out a full review of its administrative arrangements for the making of community care assessments for people with mental ill health who were to be discharged from hospital, and the support offered to their carers.

(Report 02/B/3191)

J7: Child protection

Case conference – procedural flaws – appropriate action by council

Mrs X complained about the way a council dealt with suspected child abuse.

The complaint

1. Mrs X had two sons who lived with her. Her ex-husband had visiting rights.
2. Mrs X complained that:
 - the council provided inaccurate and incomplete information to an initial child protection case conference, at which the two boys were placed on the child protection register;
 - the chair of the case conference unreasonably decided to register the boys under the category of 'emotional abuse';
 - the council failed to circulate the draft minutes of that and a second case conference to her at the same time as to other people attending, and in time for her to propose amendments to the minutes;
 - the council delayed unreasonably in producing and providing her with core assessments of her sons;
 - the council failed to provide support to her and her family; and
 - the council did not deal with her complaints properly.
3. Mrs X's concern about the category in the register was that she considered the 'emotional abuse' category implicated her. She was seeking a categorisation of sexual abuse, which she considered would make it clear that it was her husband who was at fault.

Action by the council

4. The Ombudsman noted that the council:
 - offered to recommend to the area child protection committee that the record of the previous decision should be amended to remove any reference to the incorrect registration;
 - decided to remind chairs of case conferences of the need to draw the attention of conferences to the criteria for making relevant decisions;
 - amended the procedure for circulating draft minutes, so that they were sent to professionals and family members at the same time;
 - offered to provide Mrs X with a written apology and offer a meeting with the head of children's services; and
 - offered to pay £2,500 compensation to recognise the emotional upset and stress caused to Mrs X and her time and trouble in pursuing the complaint.
5. The Ombudsman accepted that this was an appropriate basis on which to settle the complaint.

(Local settlement 02/C/6789)

J8: Residential care

Differing contributions to fees according to start date

Mr and Mrs Randel complained about a council's scheme for determining contributions to care home fees.

Fee contributions

1. Mrs Randel's mother took up residence in a private care home, having arranged her own placement and funding it from her own resources. She was aged 93 at the time.
2. Some two years later, her resources had depleted to the point where she became eligible for assistance from the council with her residential care charges. The council carried out an assessment of her care needs and financial circumstances. The weekly charge at this home was higher than the council's standard rate. A third party contribution was required to cover the difference and Mrs Randel agreed to pay this.
3. Later, Mr and Mrs Randel discovered that the council had introduced a new policy on third party contributions but only applied this new – and more favourable – policy to new residents. As a result, Mr and Mrs Randel were paying more than the relatives of those who entered the same home in later years. Mr and Mrs Randel complained that this was inequitable.

The Ombudsman's view

4. The Ombudsman agreed. She said there were two main reasons why that was so. The first was that the council should have complied with the Department of Health's directions and guidance. The guidance made it clear that costs could only vary in relation to a resident's

assessed needs, and the length of time a resident had been funded by the council was not relevant to determining the cost. The effect of the council approach was to create a situation where a different cost would be used to calculate third party contributions in respect of residents with identical needs. That was not in line with directions and guidance.

5. The second reason was a matter of common sense. The system created a nonsense because if Mrs Randel's mother had moved to a different home, or had even been temporarily discharged and then readmitted to the same home, she would have been entitled to the revised and more favourable arrangements requiring lower third party contributions than if she had always remained in the same home. That highlighted the anomaly which the council's approach created.

Outcome

6. The council changed its policy so that contributions did not vary according to the date the placement commenced. The Ombudsman recommended that the council should reimburse Mr and Mrs Randel in respect of the amount of third party contributions which they ought not to have paid.

(Report 03/C/2451)

J9: Residential care

Top-up fees – information for clients and relatives

Mr X complained about the payments a council required from him in respect of his mother's room in a residential care home.

Payments

1. When Mr X's mother first moved to the residential home, the council was not involved in the payment of fees. However, after her capital fell below the relevant threshold, the council assessed her needs. The council agreed that she needed 24-hour supervision, that her needs were being adequately met in her accommodation and that a move away from the home would not be beneficial.
2. The cost of the room was more than the council's contracted price for a single room. Mr X did not want his mother to have to move to another home and agreed to pay the top-up fee required to meet the additional cost of the room she was in at the time.
3. The following year Mr X approached the council and queried the justification for him having to pay the top-up fees. In none of the council's replies did it explain to him exactly what his contribution was paying for.
4. When the top-up fees were increased some three years later, Mr X complained again and said he did not see why he had to pay the top-up fees as they should only apply where a higher standard of provision was unreasonably demanded. The council said that payments by relatives were agreed at the time of arranging admission and were outside the remit of the council.
5. Almost a year later the council carried out a review of Mr X's mother's care. The council at that time agreed to fund the full cost of the room.

6. At this review the manager of the home said that the room was above the contracted price for a single room and that some rooms in the home without en suite facilities were often used for clients at contract prices. Mr X said he had never before been told that the top-up fees he had been paying were because of the en suite facilities.
7. Although the council agreed he did not need to pay the top-up fees any longer, it continued to send him invoices each month.

Investigation

8. The council said that, where a person was in residential care, their situation was usually reviewed on an annual basis. But the Ombudsman found no evidence that Mr X's mother's needs were reviewed over a five-year period. The Ombudsman said it would have been good practice for the council to review her needs sooner than it did.
9. The Ombudsman considered that, when Mr X raised the issue of the top-up fees, the council should have given him a more informative response. The council did not tell him that he could have the payments reviewed if his financial circumstances had changed, or that there were rooms in the residential home which his mother could potentially move to which were within the contract price. Mr X lost an opportunity to make an informed decision about contributions to his mother's care. There was no evidence that it was ever made clear to Mr X that there was a possibility of his mother moving to another room within the same home at the contract price.

10. The Ombudsman considered that the council should have reviewed Mr X's mother's needs within a month of his complaint. Had the council done that, the probability was that it would have agreed to meet the additional costs some nine months earlier than it did.

12. The council also agreed to review its procedures with a view to introducing appropriate written material for clients and relatives on the subject of top-up payments.

Outcome

11. The council agreed to refund £985 which Mr X had paid for the relevant period, to send him no further invoices, and to pay compensation of £100 for his time and trouble in pursuing the complaint.

(Local settlement 02/A/13847)

J10: Residential care

Allegation of abuse – failure to clarify issues

Mr X complained that a council did not properly investigate allegations made against him.

Parties involved

1. Mr X's adult daughter had learning difficulties. She lived in a care home run by a charity. The charity alleged that Mr X physically abused his daughter.
2. The complaint involved the charity who ran the home, the council in whose area the home was located and that hosted an adult abuse case conference, and another council that was the placing authority. The complaint as such was against the placing authority.
3. Mr X made a complaint to that authority, and that was considered under the statutory social services complaints procedure. The complaint mainly concerned the actions of the social worker involved, and his role in the allegations being made and how they were dealt with.

Independent report

4. The council commissioned an independent report. The report concluded that:
 - case recording was very poor, so that it was difficult to ascertain what happened and difficult for the council to clarify the exact nature of Mr X's complaint;
 - no formal action or investigation was undertaken in the first year when allegations were made, despite the fact that serious concerns were being raised, and the allegations themselves were never made completely clear;

- even when the council where the home was located activated its adult abuse policy, nothing was followed through, although the council did write to Mr X to say that there was no evidence to say there was anything illegal. But the placing council did not follow anything through to any conclusion, and suspicion about Mr X did continue to linger;
- an independent report commissioned by the charity completely exonerated Mr X, but the placing authority had still not confirmed in writing to him that his conduct was acceptable, or if not, what action the council was taking;
- there was no clear agreement between the two councils and the charity about their respective responsibilities;
- communication between the placing council and Mr X was poor, and that exacerbated Mr X's sense of injustice as issues were never properly addressed or concluded; and
- the situation should never have been allowed to develop in the way that it did.

Outcome

5. The Ombudsman noted that the council accepted the report's conclusion, and had offered to make a formal apology and pay financial compensation. The Ombudsman thought the council's proposed compensation was insufficient, and in his view £3,000 was the appropriate figure.
6. Mr X did not consider that £3,000 was by any means a suitable sum. The Ombudsman considered Mr X's views and took them into account, but concluded that £3,000 was a reasonable and fair resolution of the complaint.

(Local settlement 02/B/17452)