Local Government
OMBUDSMAN

Digest of Cases 2007/08

Section H

Social care

LGO 03 (03/08)

Children and family services

Introduction

When providing social care services, councils are required to assess an individual's needs, plan and then deliver the required services to meet those needs, and carry out reviews to ensure the needs are being met. In such cases councils have a duty to put the child's interest first and to safeguard and promote the child's welfare; they should make the child's welfare the focus of their decisions and actions. The cases included in this section illustrate the types of problems we typically encounter, particularly for children who are looked after by local authorities, either in foster care or residential care.

The first three examples show problems with:

- placing children in inappropriate placements;
- failing to provide appropriate levels of support; and
- failing to react and take remedial action when things go wrong.

There are also a number of cases involving issues relating to how councils hold and use information about young people. Councils must comply with the Data Protection Act, and individuals who believe their personal information has not been handled correctly may complain to the Information Commissioner. We do, however, sometimes exercise discretion to consider such complaints, where concerns about personal information are part of a wider complaint, and where the Information Commissioner would not be able to provide a remedy such as compensation.

By their very nature, these cases involve very vulnerable groups, highlighting the serious issues involved with service provision for children and families, and the consequences for individuals where councils fail to make the right provision. But they also illustrate the positive steps councils take to resolve complaints and demonstrate the impact we can have on provision for these vulnerable groups.

H1: Children in care

Inappropriate placements for young person with autism – assessed needs not met – appropriate education not provided

The complaint

A young person with autism (D) complained that the council failed to ensure his needs were met: it placed him in the wrong sort of residential placements, where staff were not trained and did not know how to look after him properly; and some placements were too far away, making it difficult for him to see his family. In addition, the council failed to monitor his care adequately, listen to his complaints or protect him from harm.

What happened

The council found a placement for D but it was not successful. He was then moved a number of times to various different residential homes. Each of these placements was flawed, because:

- they could not meet D's assessed needs (there was insufficient provision available in the area for people with autism);
- he did not receive appropriate education;
- they failed to take account of the need to be near his family – placing him far from home, so his family was unable to visit;
- the council did not check the care being given to him, monitoring was inadequate and there was a failure to respond when problems arose; and
- when the council finally identified an appropriate placement there was undue delay moving him.

As a result of these failings there were times when D was not properly looked after, causing him physical and emotional harm; on occasions he was hurt, or felt afraid and unhappy. In addition he had little or no education for over two years.

Outcome

Although the council did not accept all of the criticisms of its care of D, it did accept that there had been some fault and readily agreed to the settlement, investing a great deal of time and money to resolve the situation: it placed D at a new home with specialist staff who knew how to look after him, and found an appropriate school place.

In addition, the council agreed to:

- await the outcome of a fresh assessment before making any further decisions on provision for D;
- apologise to D and pay him £12,000; and
- introduce changes to its procedures, including a review of provision available for people with autism, and take steps to ensure that staff who looked after people with autism had the right training.

(Case reference confidential)

H2: Children in care

Children placed with foster carer without proper checks – failure to give financial or other support – failure to visit children

The complaint

Mr E, a foster carer, complained about a number of issues connected with the placement of two young children with him and his adult daughter for fostering. The children were those of Mr E's ex-partner, and were half-siblings to his adult daughter but no relation to him. The council placed the children after reports from the children's father (who was separated from their mother) and others that the children were neglected.

The Ombudsman's investigation

The Ombudsman found that the council:

- made no checks before it placed the children with Mr E and his adult daughter;
- did not visit the children for several weeks after the placement began, in breach of the fostering regulations;
- gave no financial or other support to Mr E; and
- delayed in arranging a review panel when Mr E's complaints about these issues were considered through the statutory social services complaints procedure.

The Ombudsman commented:

"The council placed two vulnerable young children in the care of [Mr E] and his daughter without even the most basic checks on them, their home and their ability to look after young children. Fortunately [Mr E] and his daughter have proved to be appropriate carers who have apparently done an excellent job in looking after the children who have come to no harm. This is no thanks to the council."

Outcome

The council agreed to pay Mr E and his daughter £10,350 representing the foster care allowance that Mr E should have received. The Ombudsman also proposed that the council should:

- review its practices and procedures to ensure that there would be no repetition of children being placed with carers without proper checks being made;
- conduct an audit of other emergency placements; and
- make quarterly reports to the appropriate council committee on complaints received under the statutory procedure.

(Report 06C00693)

H3: Children in care

Siblings of adopted child placed close by, contrary to recommendation – delay in taking action after mistake realised

The complaint

A couple who had adopted a child complained that the council wrongly placed the siblings of their adopted son close to their home in a small town, despite an indication on file that he should not have any contact with his birth family.

What happened

The council realised its mistake the same day and promised to move the other children immediately – but failed to do so. By the time the complaint came to be considered by the Ombudsman, three years had gone by and it would have disadvantaged the siblings to move them again, so they were able to stay in their placement nearby. The complainants were therefore left with the possibility that their adopted child might be contacted or recognised by members of his birth family, which would be to his disadvantage.

Outcome

The council accepted it had been at fault in failing to rectify the error by moving the siblings away. It agreed to the following steps to settle the complaint. It would:

- carry out a review of its policy and procedures, with the complainants able to comment on the council's proposed changes to its policy;
- pay £2,000 to be held in trust for the benefit of their adopted child; and
- agree that if something went wrong in the future as a result of the placements, they could complain to the Ombudsman again.

(Case reference confidential)

H4: Children in care

Young person moved from residential placement without warning or consultation – placed in children's unit where he was bullied – no meaningful action by staff in response to his complaints

The complaint

F was a young person who had had a chaotic home life. It was known that, without proper structures, his behaviour would become difficult. He was in a residential placement but was moved from there without any warning or consultation. He was then placed in another residential unit that had previously been the subject of a complaint to the Ombudsman about bullying. Some of his possessions were lost in the move.

The unit was scheduled for closure and was in a dilapidated condition; it had been described as 'appalling' the previous year and had deteriorated further since then. He was younger than the other residents and was bullied by them. There were no meaningful interventions by staff who witnessed the bullying. He understood he would get a place at a new unit, but this did not happen. He complained, but little was done and he felt constrained from pursuing his complaint until he was moved to another placement.

The Ombudsman's view

The Ombudsman found fault because the council:

- implemented his care plan without assessment, social work and other appropriate support, and moved him without finding out what he thought first;

- didn’t do enough to stop F being bullied at the children’s unit where he was placed, putting him at risk of being badly hurt; and
- took no meaningful action in response to his complaints about what was happening at the unit.

The council’s failures meant that F felt that no-one was listening or caring, was afraid and unhappy, and was at risk of physical harm.

Outcome

The council agreed to apologise to F and pay him £2,000.

(Case reference confidential)

H5: Child protection

Child protection case conference – disclosure of confidential information

The complaint

Miss G complained that:

- she was unable to prepare properly for a child protection conference as the social work report was only shared with her five minutes before the start of the meeting;
- she suffered embarrassment and distress as a result of a social worker's disclosure of confidential information at a case conference without her consent; and
- she was caused further distress by the social worker asking her to sign a contract agreeing that she had abused her daughter – she denied any abuse.

What happened

A case conference was held to consider allegations that Miss G had failed to care for her daughter properly. One of the main reasons for calling the case conference was the issue of her daughter not taking medication. During the initial case conference, a doctor's report was faxed through and a break was taken for her to read it. The report clearly stated that her daughter’s time off medication was undertaken on the advice of the doctor. This letter was not distributed with the minutes and it was not clearly stated in the minutes or subsequent case recording that this information had been provided by the doctor.

Miss G felt that her name had not been cleared and that the council's actions had caused her problems with professionals, in that her previously good relationship with her daughter's school and GP were affected.

The council had circulated a letter, with Miss G's approval, to set the record straight, but had failed to apologise to her for what had happened.

The Ombudsman's view

The Ombudsman's view was that, since the issue of Miss G's daughter not taking medication was one of the main reasons for calling the initial child protection conference, it should have been made clear to all involved that this issue was no longer considered to be of concern as a result of the doctor's report.

The Ombudsman also accepted Miss G's view that she had been unable to prepare properly because she had only received the report five minutes before the case conference, and that she was caused unnecessary distress and embarrassment when a social worker:

- disclosed personal information about her admission to hospital in the presence of her daughter's teachers and her father, who knew nothing about this; and
- asked her to sign a contract agreeing that she had abused her daughter.

Outcome

Following her complaint to the Ombudsman, the council agreed to send a formal written apology and pay Miss G £3,000 for the distress she had suffered and the time and trouble she had taken in pursuing her complaint.

(Case reference confidential)

H6: Child protection

Doctor's concern over accident to child – case conference held without the doctor present and no written report from her

What happened

Mr and Mrs H took their 14-month-old son to a hospital's accident and emergency unit (A&E) after a fall. A doctor suspected a fractured skull, and was concerned about the number of A&E presentations by the parents over the past year. As a result of the doctor's concerns, social

services interviewed Mr and Mrs H in the presence of their other child (aged four). The council arranged a case conference without ensuring that the doctor could attend or alternately circulate a report about her concerns prior to the conference.

The child protection case conference decided that there was no reason to register the child but recommended a core assessment. Mr and Mrs H co-operated and no further action was taken after this.

The Ombudsman's investigation

As the medical evidence was the crucial information that needed to be considered at the initial case conference, the council was at fault in proceeding with the conference without a written report from the doctor, which could have been circulated in advance of the meeting, and an assurance of the doctor's attendance at the conference. Indeed the council's independent reviewing unit advised both of these should take place.

The council's booklet recommended seeking advice from someone 'like an advocate or a solicitor'. Mr and Mrs H employed solicitors. They argued that they would not have needed a solicitor if the council had carried out a better child protection investigation.

Outcome

Mr and Mrs H's concerns were justified, so the council agreed to meet their legal costs, make a payment for avoidable distress, and review its booklet.

(Case reference confidential)

H7: Child protection

Inadequate investigation into abuse allegations

The complaint

Mr and Mrs J alleged there had been an inadequate child protection investigation into allegations of child abuse made against Mr J.

What happened

The council's own investigation upheld much of the complaint, finding, among other things, the following failings:

- information was not sought properly from the relevant sources;
- notes of important interviews were not made;
- inappropriate information was passed to Mr and Mrs J's daughter;
- the core assessment contained information that was not true, or was mistaken or uncritically repeated, and some of the language and expressions used were judgemental or prejudicial;
- the process of conducting the information sharing and decision making through the senior strategy meeting did not allow an open and transparent approach. Mr J was told he could not have access to the notes of the senior strategy meeting, which added to the sense that this was a group without accountability. These notes were eventually released, allowing inaccuracies to be challenged (this complaint was partially upheld);
- the council refused to accept the finding of not guilty from the crown court, and persisted in the belief that Mr J was a risk in spite of there being no evidence or suspicion on which to base this belief. As a result, Mr J's name was kept on a register for six months longer than necessary.

Outcome

The council agreed to pay £1,250 for the family's avoidable distress and inconvenience and £250 for their time and trouble in pursuing this matter. It also made a number of improvements to practice, to the benefit of other service users.

(Case reference confidential)

H8: Access to personal information

Misleading information given about birth family

What happened

The council gave Mr K misleading information about his birth family when he was trying to trace his mother. When it transpired that information had been incorrect, Mr K suffered great distress and upset at the possibility that he had wasted 10 years when he might have been able to find his mother.

Outcome

The council agreed to arrange a meeting with a representative of the British Association for Adoption and Fostering to examine Mr K's file (and pay his travel and overnight expenses), and to refund search fees he had already spent on the basis of misleading information.

(Case reference confidential)

H9: Access to personal information

Wrongful access to personal information – council delayed in investigating complaint

The complaint

Mr L alleged there had been a breach of confidentiality with a member of the maternal family of his grandson gaining access to records. He said that resulted in him, his wife and his son not having contact with his grandson for seven months.

What happened

After complaining to the council, Mr L had to make several attempts to find out about progress. A council officer informed him that a member of staff had been suspended pending an investigation, but he was not kept informed of progress. The council accepted that there was delay in moving the complaint to the investigation stage. This was a result of the heavy workload faced by its officers.

Outcome

To address this problem, the council employed independent qualified investigators. The complaint was then fully investigated and it was confirmed that there had been wrongful access to information.

The council apologised for the distress that the wrongful access of information may have caused Mr L and his family. The council took specific action to address this complaint and more general action to prevent a recurrence of what had happened, setting up a new robust electronic filing system that would limit access to information by users.

(Case reference confidential)

H10: Access to personal information

Former 'looked after' child – request for access to care files – no record kept and no action taken for a year

The complaint

Mr M (who had been a 'looked after' child) requested that the council allow him access to his care files. The council failed to keep a record of this request and no action was taken. A year later Mr M's advocate wrote to the council asking why nothing had been done. The council responded that a subject access request had now been submitted and it would provide the files.

What happened

The leaving care team (LCT) manager explained that it took some time to go through the files and seek third party permission to disclose the papers. He asked Mr M if there were particular periods that he would like to see first as he could arrange access to those as a priority.

The LCT manager met Mr M again and discussed a timeline and significant events that had happened in Mr M's life. Mr M reiterated that he wanted to see all of his files and the council agreed to electronically scan and edit them. A formal complaint about delay was lodged with the council a few days later. The council responded that it was dealing with the access request and apologised that the earlier request had been lost. It also apologised for its current delay. That same day a stage three complaint was sent to the council and it was asked to consider financial redress.

The council replied to the stage three complaint, apologising again for the delay in providing access to the files which were now ready to be seen. It also stated that it would not pay redress because Mr M had not incurred any financial losses. On the same day the chief executive sent a memorandum to the deputy director stating that the complaint was fully justified and it seemed that it was failing to fulfil its statutory duty. As a result, additional staffing was to be sourced and other options considered to improve matters.

Mr M had to wait an undue length of time (more than 18 months) to see files that contained difficult and deeply personal information about his past. The chief executive was correct to state that the council failed to meet its statutory duties and targets in this case. The delay caused a great deal of distress and frustration that could have been avoided.

Outcome

The council agreed to:

- pay Mr M £500 (£300 for distress and £200 for time and trouble); and
- detail what measures had been put in place to improve the handling of subject access requests made by people leaving care and how those measures would be monitored. This was particularly important as Mr M wanted to know that the council was seeking to prevent similar failings recurring.

(Case reference confidential)

H11: Direct payments

Support for disabled child – full payments not made

The complaint

Mr N was a young person who became quadriplegic following a serious illness. When he returned home the council failed to support him adequately with social work visits, and failed to assess his care needs and the needs of his parents as carers properly. As a result they did not receive the full direct payments they were entitled to. This meant the whole family was placed under additional unnecessary pressure to meet all Mr N's needs without help or being able to take a break.

What happened

An initial assessment did not reflect Mr N's true needs and it was not until some months later that an adequate assessment was done. In addition, Mr N's parents were never told that direct payments could be backdated. Also, no carers' assessment was considered or offered to them for a period of two years, during which the whole family experienced a traumatic change to their lives. The carers' needs should have been assessed from when their son left hospital and reviewed on a regular basis. The council failed to provide a carer's assessment for Mr N's parents and did not identify the need for Mr N to have respite care until they were exhausted.

Although the council maintained that social workers or managers were always available and involved, there was a lack of direct support at a time when the family was particularly vulnerable, given the extent of the Mr N's needs and disabilities.

Outcome

The council agreed to:

- backdate direct payments of £37,000;
- carry out regular reviews every three months and reassess Mr N's needs when they change and his parents' needs as carers; and
- pay £2,000 for shortfall in the service and the time and trouble taken in pursuing the complaint.

(Case reference confidential)

Adult care services

Introduction

When providing social care services, councils are required to assess the needs of individuals, plan and then deliver the required services to meet those needs, and carry out reviews to ensure the needs are met. The Ombudsmen receive complaints across the whole of this process, covering issues such as:

- inadequate assessments – failing to assess needs properly;
- flawed criteria for assessments and for making decisions;
- failure to follow Government guidance; and
- failure to provide services to meet assessed needs.

More services are now being commissioned from independent providers or delivered in partnership with other bodies such as health trusts. Social care is an area where complaints often cover different organisations and, with the Government pressing ahead with a new joint complaints process between health and social care, this trend looks set to continue.

Since the introduction of the Regulatory Reform (Collaboration etc between Ombudsmen) Order 2007, the Ombudsman may now conduct joint investigations with the Parliamentary and Health Service Ombudsman, and one of the cases below is an example of a joint report being issued.

These cases highlight the serious issues involved with adult care service provision and the consequences for individuals where councils fail to make the right provision. But they also illustrate the positive steps councils take to resolve complaints – even where, in one case, the council had not been at fault.

H12: Residential care

Standard of care for severely disabled adult – confusion between council and health trust over who was responsible for aspects of the complaint – joint investigation by Local Government Ombudsman and Parliamentary and Health Service Ombudsman

The complaint

Mr P's parents complained to the Local Government Ombudsman and the Parliamentary and Health Service Ombudsman about the care their severely disabled adult son received while he was living for two years in a residential care home run jointly by a county council and a health trust. Mr P needed one-to-one attention for about 95 per cent of his waking time.

What happened

While he was at the care home, Mr P's care needs were never properly assessed, and a number of significant failings in the level of care he received were identified. Although Mr P's parents voiced their concerns to the trust and the council, there was delay in responding to these concerns and a great deal of confusion as to which body should address the separate aspects of the complaint. While at home during a Christmas break, Mr P suffered from anxiety and depression and refused to leave the house. His parents accommodated him at home without any external support for three months, until he was returned to the council's care. When his needs were finally assessed, and a care plan prepared, he was moved to a residential home that provided the level of care and support that an adult with his complex needs required.

The Ombudsmen's joint investigation

The Ombudsmen's report said Mr P and his parents had a right to expect that the care home would provide him with appropriate care in an environment conducive to his development, but sadly that did not happen. His needs were not assessed properly. This absence of a proper assessment and, in turn, a proper care plan, led to a failure to ensure his physical or emotional wellbeing was protected. The council failed to provide appropriate residential services to Mr P on transfer from the local mental health trust. The accommodation provided did not meet his needs, and support and other services fell well short of what was necessary and appropriate for a person with such complex needs. As a result, Mr P's parents paid for various outgoings which should have been paid for by either the trust or the council.

Outcome

The Ombudsmen found that there had been fault by both the council and the health trust that caused adverse effects for Mr P and his family, including acute anxiety, distress and some financial loss. The Ombudsmen recommended that the council and the health trust pay £32,000 compensation.

Joint working

This was the first time that the Local Government Ombudsman and the Parliamentary and Health Service Ombudsman had collaborated on an investigation in this way. Although they had separate jurisdictions over different parts of the complaints, many aspects of the complaints were inextricably linked. The Ombudsmen reported jointly using new powers under the Regulatory Reform (Collaboration etc. between Ombudsmen) Order 2007 to work together more effectively in investigating and reporting on complaints which cross their jurisdictions.

The Ombudsman said:

"Collaborating with the Parliamentary and Health Service Ombudsman in this way … is an important step forward. One of the outcomes of this case has been identifying the need for robust and transparent governance arrangements to be in place in order to provide clear accountability for the actions of authorities. A complainant can then be more readily signposted to the body that can better deal with a complaint."

(Report 03A04618 issued jointly with the Parliamentary and Health Service Ombudsman: 'Injustice in residential care: a joint report by the Local Government Ombudsman and the Health Service Ombudsman for England' was laid before Parliament on 26 March 2008.)

Mental health aftercare

Where someone is detained for treatment under the Mental Health Act, section 117 of the Act gives them a right, on being released from detention, to free aftercare from health and social services authorities, until the authorities are satisfied the person no longer needs such services.

In 2003 the Ombudsmen issued a special report on this topic as a result of complaints showing that many authorities were charging people for services that should have been provided without charge. We still, however, receive complaints showing that problems continue in this area, as the following three cases illustrate.

H13: Mental health aftercare

Aftercare for woman whose husband became too ill to care for her – placed in nursing home at council's expense – son requested both parents be moved to a home nearer his – council allowed move but did not consider effect on payment of fees

The complaint

The late Mrs Q had a history of mental illness and had been detained in hospital under the Mental Health Act 1983. She was discharged with a care package provided under section 117 of the Act. Later on that year her husband, Mr Q Sr, who was his wife's main carer, had a stroke and so was incapable of caring for his wife or himself. The council placed Mrs Q in a nursing home and funded her care there.

The couple's son, Mr Q Jr, asked the council to move both his parents to a home nearer his, in a different part of the country. The council said that, as Mrs Q received section 117 aftercare, it would need to get legal advice. It decided that Mrs Q could move, but did not mention the effect that her discharge from the home would have on payment for her aftercare. Mr Q Sr died shortly after the move, and Mrs Q lived at the new nursing home until her death. Her son paid the fees.

Mr Q Jr subsequently enquired about the way the section 117 aftercare order had been discharged. The council decided that this was done correctly, although it could not provide evidence to substantiate its view.

The Ombudsman's investigation

The Ombudsman found that the council failed to carry out a proper assessment of Mrs Q's mental health needs to establish if section 117 aftercare was no longer required. It also failed to hold a multi-disciplinary meeting with the relevant professionals, the patient and her carer or nearest relative to review the care plan. As a result of these failures, Mr Q Jr had to bear the full cost of care for his mother until she died.

Outcome

The Ombudsman recommended that the council compensate Mr Q Jr for the cost of his mother's nursing home fees, amounting to £33,455.58, plus interest at the relevant county court rate.

(Report 06B07542)

H14: Mental health aftercare

Payment for residential care – assessed need for frequent contact with family – top-up payments

The complaint

Mrs R, who needed aftercare under section 117, became a resident in a care home. Her daughter, Mrs S, complained about the issues of payment for care and whether the home selected by the council could meet her mother's assessed needs.

What happened

The law and guidance on responsibility for fully funding the costs of aftercare under section 117 is clear. However, there is no specific statutory provision, case law or guidance on whether someone needing section 117 aftercare and wanting to go into a more expensive home can meet the difference between those costs and the costs that a council would incur for a home that could meet assessed needs equally well.

The council initially said that only a third party could meet the additional costs of a home chosen by the family for Mrs R. It then reviewed that decision and concluded that it would be reasonable for Mrs R to meet the difference in costs from her own resources.

A home in the council's area had vacancies, and the council said that this home could meet Mrs R's needs. The council therefore refused to pay any more than the amount of that home's fees. However, Mrs R's care plan included frequent contact with family members. The home that the council said could meet her needs was in a rural location and difficult for family members to reach. Mrs S complained about the decision that her mother should be placed in this home.

The Ombudsman's view

The Ombudsman found that the council:

- had not considered properly whether the home it had identified would meet Mrs R's assessed needs, nor taken into account the impact on family contact; and
- had delayed reviewing its initial decision about third party 'top-up' payments after representations from Mrs S, her MP and her solicitors.

If the council had considered Mrs R's assessed needs properly and reviewed its decision about 'top-up' payments sooner, unnecessary distress to Mrs S would have been avoided. The Ombudsman commented:

"In the absence of specific guidance or case law on the subject of 'top-up' payments related to Section 117 aftercare, local authorities need to take care when reaching decisions on individual cases. A council should be able to show that it has: considered all relevant factors including the particular circumstances of the individual case; reached a reasoned decision without undue delay; and considered any representations that it receives with an open mind. If this can be shown, I would be unlikely to criticise a council or find maladministration."

Outcome

The council accepted that the home chosen by the family was appropriate, and agreed to meet the full costs. It also paid Mrs S £500.

(Report 05C13158)

H15: Mental health aftercare

Wrongful discharge from aftercare – wrong test applied

The complaint

Mrs T's solicitor complained that the council unreasonably discontinued funding of aftercare which she was entitled to receive under section 117 of the Mental Health Act 1983.

What happened

Mrs T was discharged from hospital following a period of detention under the Mental Health Act 1983. Initially the council funded her aftercare in a residential care home under section 117. However, following a review of her case, the council determined that Mrs T was settled in the home and no longer needed aftercare, so could be discharged from section 117.

The test that was applied – whether or not a person is 'settled in a nursing or residential home' – was an irrelevant consideration. The key question should have been, would removal of this person (settled or not) from this nursing or residential home mean that she was at risk of readmission to hospital. If the answer was 'yes' then she could not be discharged from aftercare.

The Ombudsman's view

The Ombudsman found that the discharge criteria applied by the council were seriously flawed and its decision about Mrs T's continuing need for aftercare was, therefore, unsafe. The decision that Mrs T was no longer at risk of readmission to hospital was fatally flawed because the vital contribution of the residential home to her section 117 aftercare was ignored. The Ombudsman said:

"The practical effect of the council's criteria is to remove long term nursing or residential home accommodation from the definition of aftercare services. If that were to remain the position, the council's criteria would allow it to avoid its public responsibilities under Section 117 of the Mental Health Act 1983."

Outcome

The council had applied the discharge criteria to a number of other cases, some of which had not been reviewed. The council argued that, despite any flaws in the criteria, those decisions were likely to be safe. But the Ombudsman nevertheless recommended that the council should further investigate these cases to ensure that no maladministration had occurred, if necessary involving a suitable independent person to assist.

The council agreed to:

- review its section 117 discharge criteria with the assistance of external legal advice and then reassess Mrs T's need for continuing aftercare services;
- pay Mrs T's residential care costs until such time as a new review properly determined whether she needed aftercare services under section 117; and
- pay Mrs T's family compensation of £250.

(Report 06B16774)

H16: Care charges

Assessing individual's resources for calculation of charges

What happened

The council decided that Mr V had sufficient capital to cover all residential care fees. As a result he was given no assistance towards the cost of care home fees. However, the council had failed to determine Mr V's resources properly and the decision was therefore flawed.

Outcome

Although there had been poor consideration of relevant factors, poor decision making and poor communication, once the complaint was made to the Ombudsman the council agreed a speedy resolution. After reviewing the file, the council agreed that it would not treat the value of Mr V's interest in a property as part of his resources, would reassess its contribution to his care home fees and backdate to the date he entered residential care. Any payments his family made in the meantime to maintain his placement were to be reimbursed.

(Case reference confidential)

H17: Care charges

Assessment of charges – failure to follow Government guidance

The complaint

Mr W complained about the way the council handled an increase in charges for his care.

The Ombudsman's view

Where a council has assessed someone's needs and decided what services to provide, it then carries out an assessment of their ability to pay charges and decides what payments they should contribute to the cost of care. The relevant Government guidance makes it clear that no charges should be made for any period before the assessment was done. In addition, where charges are subsequently increased, any increase should be notified and the increase should only be sought from the date when the person is told about it.

In this case, when the council increased its charges, it sought to backdate the increase to cover the care provided before Mr W was notified of the increase. This backdating of charges was a clear contravention of the guidance.

Outcome

The council agreed to:

- refund the backdated charges to Mr W;
- refund backdated charges to any other service user who made a complaint; and
- introduce a new system to ensure that future increases would not be subject to backdating.

(Case reference confidential)

H18: Assessment and provision

Inadequate assessment – failure to identify fully and provide for needs

What happened

Mr X sought a reassessment of his needs and an increase in the provision made for him. Although the council did reassess him, it failed to take proper account of his needs for about eight months. This lack of a sufficiently thorough assessment amounted to administrative fault that caused Mr X injustice – the care assessments failed to take account of all issues affecting him, and so insufficient hours of care were provided. The assessments also failed to address the issue of bed linen being persistently damaged through Mr X being obliged to sleep in his boots (he wore special boots and was unable to take them off without assistance).

In addition, the council ceased to pay for Mr X's care when he refused to accept a male carer following a complaint from his previous female carer. He then found his own carer but the council did not offer the option of direct payments for six months. Mr X was, therefore, obliged to pay for extra hours of care himself, using his disability living allowance.

Outcome

The council agreed to reimburse Mr X's care costs of nearly £4,000 and pay him £500, comprising £250 to replace bed linen and £250 for his time and trouble in pursuing his complaint. It also agreed to arrange for a physiotherapy assessment to be carried out.

(Case reference confidential)

H19: Information for service users

Provision of information about services – helpful response from council

The complaint

Miss Y, who had mental health problems, claimed that there was a lack of information available for service users and that the council had failed to respond to her specific requests for information.

Outcome

The Ombudsman did not find fault by the council. Nevertheless, the council arranged for Miss Y to have a meeting with a senior manager at which they could discuss her concerns and the provision of information, and arranged for an advocate to provide support and take notes for Miss Y at the meeting.

This is an example of a good response to a complaint by the council concerned. Even though there was no evidence of fault, it agreed to settle the complaint by providing information for the complainant in a way that suited her.

(Case reference confidential)