Local Government
OMBUDSMAN

Digest of Cases 2008/09

Section L

Social care

LGO 03 (03/08)

Children and family services

Introduction

The main feature in the cases summarised here is delay, in some cases amounting to years, when proper provision was not made for vulnerable children and young people. In some of these cases councils have failed to comply with their duties regarding assessment and provision for children in need.

The importance of the provision of accurate and timely information for children and their carers is also emphasised. In one case (L7) the council failed to explain and take responsibility for lost records, resulting in the person concerned spending years trying to find out which council had been responsible for her care.

L1: Children in care

Complaint made on behalf of three girls in care looked after by maternal aunt – failure to carry out important social work tasks despite previous Ombudsman recommendations

Background

Mr and Mrs F looked after Mrs F's nieces, aged 16, 14 and 10 who were in local authority care. A fourth niece had been adopted. Mr and Mrs F also had three children of their own to care for. Mrs F made a complaint with the help of the Children's Legal Centre about the council's failure to take action that it had agreed. The Ombudsman had previously dealt with a similar complaint from Mrs F which resulted in the council agreeing to recommendations made by the Ombudsman. Mrs F was concerned that the service the children were receiving had not improved.

The investigation

The investigation found that the council had delayed in:

- tracing the girls' birth fathers;
- completing life story work with the girls;
- obtaining up-to-date information about their mother;

- arranging contact with their younger sister; and
- ensuring they had an allocated social worker to check on their progress.

This lack of action compounded the girls' distress at being in care.

The remedy

The council agreed to carry out all of the above tasks and provide an update to the Ombudsman six months after closure of the complaint. In addition the council agreed to:

- make arrangements for the loan of laptops for each of the girls to help them with their education;
- pay £350 into each of the girls' trust funds;
- make available £100 for each to take part in school activities (school trips etc);
- pay Mrs F £250 for the time and trouble she took in making the complaint.

The council changed its care planning procedures to ensure proper tracing of birth parents and to allow for the purchase of additional capacity if necessary to avoid future delays in life story work.

(Case reference confidential)

L2: Children in care

Child in the care of the council neglected – five years without counselling and therapy to deal with sexualised behaviour – failure to act as corporate parent

The complaint

Mr and Mrs P complain that two councils, council L and council S, failed in their statutory duty to provide therapy to their foster son, X, as recommended, and to agree a placement for his secondary education within specified time limits. They also say the councils failed to liaise with each other, resulting in significant delay to the issue of a statement of special educational needs and delay in the provision of the therapy X needed.

What happened

X was in the care of council L after suffering severe neglect in his early childhood and witnessing violence and sexual acts. He was placed with foster parents in the area of council S. Council L was his 'corporate parent', meaning that it must offer everything that a good parent would provide. X had displayed sexualised behaviour that led to an assessment and therapy for him. His therapist recommended further assessment and therapy should this behaviour continue. In subsequent years, further incidents were reported.

The Ombudsman's investigation

After a referral by council L, the NSPCC undertook an assessment of X leading to a year's therapy. The assessment carried out at the end of this therapy led to further more intensive work. The Ombudsman concluded that council L had unreasonably delayed the assessment and provision of X's therapy following the reports of further sexualised behaviour, contrary to the therapist's advice.

X's educational provision was the responsibility of council S and, when he was due to start secondary education, it commenced the consultation process for deciding what his provision should be. The process took two years. The Ombudsman concluded that council L had unreasonably delayed assessing the school preferred by the foster parents until after council S had issued the statement of special educational needs.

The Ombudsman's view

The Ombudsman said he fully endorsed council L's view that, in its role as corporate parent, it should "…offer [X] everything that a good parent would provide and more…and that all aspects of the child's development should be nurtured." He commented "Given this clear understanding of its role as corporate parent it is indefensible that it failed to follow up the recommendation … to pursue further assessment of [X]'s needs in respect of his sexualised behaviour." X was without counselling or therapy for five years.

The Ombudsman was also critical of council L's delays over assessment of a school at the time of X's transfer to secondary education. He made no criticism of council S.

Outcome

The Ombudsman found maladministration causing injustice, and recommended that council L should apologise and pay Mr and Mrs P £3,000 on X's behalf.

(Report 07B04286)

L3: Children in care

Complaint made by young person with help of advocate – failure to consult over placement and care plan – delay in providing information and assessment

Background

A 14-year-old boy, C, was living with foster carers. There were allegations of aggressive sexualised behaviour that C denied. The foster carers gave notice that they wished to end the placement. C was moved to a residential placement with education for assessment. C complained through an advocate that he had not been consulted, he had not been given accurate information and when he tried to give his view it was not taken into account. The complaint was considered and partially upheld by the council through the Children Act complaints procedure, but C was not happy with the outcome and so he complained to the Ombudsman.

The move to a residential placement

In September 2006 C's foster carers gave notice to the council that they wished to end the placement. In October the council began looking for a residential placement, based on a recommendation made in a report prepared by a psychiatrist who had not met C. The Looked After Children (LAC) panel approved a residential placement on 20 December. C was not informed of this until his social worker spoke to him on 8 January. The only reference to the meeting with C is in a casework update for the team manager of the Looked After Children Team on 29 January 2007, in which it was noted that the social worker had discussed the issue of possible residential care with C and he had said he would like to remain in foster care. A referral was made for a residential place and for C to stay for one night in February 2007.

There was no evidence that C was offered an opportunity to put his views at a LAC review meeting, nor that he was offered the services of an advocate. C himself contacted the Office of the Children's Rights Director on 15 January. They put him in contact with Voice who became involved as his advocate and who decided that the only way to get his views heard would be by making a complaint. Plans for C to go to the residential placement continued.

In March 2007, C refused to go to the placement and he was found short-term fostering. A LAC review was arranged so that he and his advocate could attend to put his views. However, the meeting was cancelled, and he was moved to the placement because the council was informed that the place would not be kept open for him pending the outcome of the meeting.

Information about the length of time C would stay at the residential placement was contradictory. He said he was told he would be there for a four-week assessment; the placement said assessments took 12 weeks and the files indicated that the plan was for him to stay for 52 weeks

– in line with the recommendation made by the psychiatrist. C was at the placement for just over a year.

Delay in assessment

C's care plan indicated that the intention was that he would remain in the placement until all of the assessments had been completed. Although he received some therapy soon after arriving, the psychiatric assessment did not start until August 2007 and was completed in December 2007. C moved to new foster carers in April 2008.

Conclusion and outcome

Although the council had partly upheld C's complaint, the Ombudsman's investigator found that:

- there was evidence of a failure to communicate and consult C about plans for his future, and that the £250 time and trouble payment recommended by the council's review panel failed to recognise this;
- there was also no apology in the letter described by the council as the "definitive response", despite a recommendation from the review panel that there should be; and
- part of the delay in assessing C was due to the council not providing information to the residential placement to assist with the assessment.

In recognition of these failures the council agreed to

- provide a proper apology to C for the failures identified; and
- make a payment of £750 in recognition of the failures in addition to the £250 already offered for his time and trouble.

(Case reference confidential)

L4: Children in care

Failure to provide residential therapeutic placement with educational provision – failure to accommodate under S20 of the Children Act

What happened

A complaint was made via the Children's Legal Centre for a young man, B, who had an assessment in March 2001 when he was 12 years old under S17 of the Children Act 1989. It concluded that B should be offered a residential therapeutic placement with educational provision. Despite a recommendation by a child protection case conference held in March 2001 that

provision should be made “within four weeks”, no serious attempts were made to find a suitable place until March 2004, after B’s adoptive mother had submitted an appeal against the content of a statement of special educational needs. A residential placement was provided in November 2005 when B was 17 years old. He stayed there until summer 2006.

Between 2001 and 2004 there were several references in B’s files to his adoptive mother being unable to cope with him, or being frightened of him and of making repeated requests for a residential placement that would provide behavioural support and education. Her requests were supported in reports from social workers and a consultant child and adolescent psychiatrist.

The law

Section 20 of the Children Act 1989 provides that, where it appears to a local authority that a child in need within its area requires accommodation because there is no-one who has parental responsibility for him or because the person who has been caring for him is prevented from providing him with suitable accommodation or care, for whatever reason, the authority has a duty to provide accommodation for him.

Conclusion and outcome

The council accepted that it had failed to make provision for B between April 2001 (four weeks after the child protection case conference) and November 2005, when he moved to a therapeutic residential placement with education.

In addition, the Ombudsman’s investigator said:

“Given the clear evidence that B posed a risk to himself and his adoptive mother, that he was considered at age 12 to be beyond parental control, that there continued to be serious concerns about his mental health and that his needs were long term, I believe it is safe to say on the balance of probabilities that accommodation should have been provided under section 20. The failure to do so, in my view, caused a further injustice to B, in that he was deprived of the opportunity to access leaving care services which he might have been eligible for under the Children (Leaving Care) Act 2000.”

The council agreed to:

- apologise to B for its failure;
- make a payment to him of £18,300 - a calculation based on £1,000 per term for the loss of education plus an additional amount for the loss of therapeutic support;
- offer him the services he would have been offered if he had been a care leaver, by appointing a personal adviser and arranging a meeting for him with the adviser to draw up the equivalent of a pathway plan, taking into account B’s wishes, needs and welfare;

- depending on the content of the plan, provide assistance with housing, employment, education or training equivalent to what would be provided under the Children (Leaving Care) Act 2000; and
- assess B for a leaving care grant under the council's policy as if he were leaving care in 2006.

(Case reference confidential)

L5: Looked after children and young people

Failure to provide pathway plans – failure to acknowledge entitlement to social housing for former unaccompanied child asylum seeker who had been in council's care since the age of 16

The complaint

The complaint was made by an advocate on behalf of Ms F, who was a former looked after child, that is a young person who has been looked after by the council and is entitled to continuing support under the provisions of the Children (Leaving Care) Act 2000. The complaint was that the council had failed to fulfil its duty to provide pathway planning to help Ms F to move towards independent living.

What happened

The complaint was considered by the council and it was accepted that there should have been an up-to-date pathway plan. The only plan that had been done was dated 2006. The Ombudsman's investigator established that, although there was no plan, the council continued to treat Ms F as a former looked after child and to provide her with support.

However, there were some failings in communication between the social services and housing departments that resulted in delay in Ms F being awarded priority for housing. This was in part due to social services only establishing in October 2007, after seeking counsel's advice, that Ms F was eligible for social housing and making the referral to the housing department in January 2008; and in part due to failure by the housing department to accept the social services department's view that Ms F had such an entitlement. Even after the social services department provided details of the legal advice it had received (that confirmed that the council owed a continuing duty to Ms F) the housing department decided that, because Ms F had a child, she did not qualify for accommodation as a care leaver.

The council's provision for care leavers was limited to studio properties. She was eventually offered a studio property, which she refused. The council then recognised that she should have been eligible for a two-bedroom property and agreed to classify Ms F's application as urgent and offer her the next available suitable vacancy.

Outcome

There were a number of other care leavers with priority for housing. The Ombudsman's investigator examined these to ensure that the offer to treat Ms F's application as urgent was a practical and acceptable resolution. In the light of the number of other applicants and their different circumstances, and the fact that Ms F had continuing support, even without the pathway plan, it was accepted that the priority for housing was a satisfactory settlement. To avoid a similar situation, the council agreed to ensure that housing for care leavers was not restricted to studio properties. The council had already taken action to address the problems with provision of pathway planning.

(Case reference confidential)

L6: Looked after children and young people

Financial support for woman caring for step-granddaughter – failure to inform of financial consequences of obtaining a residence order – fettering of discretion

The complaint

Mrs G complained that a council failed to tell her that funding of £90 per week, which she was receiving from the council for looking after her step-granddaughter, J, would be withdrawn after she obtained a residence order from the courts. Mrs G considered that the council's policy on funding was too rigid and failed to take account of her particular circumstances.

Mrs G struggled to fund the nursery fees for J. She felt abandoned by the council and scared that she would not get help in the future should J's health suffer because of her mother's excessive alcohol consumption during pregnancy.

The Ombudsman's investigation

The Ombudsman found fault by the council because it:

- failed to tell Mrs G what the payments it made to her were for, or whether they were time limited;
- did not carry out the means test before Mrs G went to court for the residence order, contrary to its own policy/procedure;

- did not give Mrs G all the information needed about the options available to her so that she could make an informed decision about what they meant for J and her future care; and
- fettered its discretion in the way it assesses means tests for residence order allowances, failing to take into account individual circumstances.

The Ombudsman's view

The Ombudsman said: "While councils have responsibilities to 'children in need', they also have responsibilities to provide proper support to those people who agree to take on the primary care and upbringing of such children." He added "I feel [Mrs G] was let down by the council."

Outcome

The Ombudsman found maladministration causing injustice, and the council agreed to:

- pay Mrs G £7,500 compensation; and
- pay Mrs G £90 per week until she is reassessed under a new means test, when it is finalised.

(Report 07A02887)

L7: Access to personal information

Lost care and adoption records – failure to provide information – failure to deal with complaint properly

The complaint

Ms P was adopted as a child. In 1996 she tried to find out more about her past by seeking her care and adoption records. The council that had dealt with her early years ceased to exist as a result of local government reorganisation in 1974. From then the council against whom Ms P made her complaint was responsible for the area where Ms P had lived. When Ms P contacted the council requesting her file she received numerous responses, none of which explained that the council was responsible for maintenance of her file and that the file had been lost some time between 1977 and 1996.

What happened

The council advised Ms P to contact the court and the registrar general for permission to obtain information. Ms P and her solicitors contacted several courts and councils in the region in an attempt to establish whether any records were held and which council was responsible. Ms P ran into difficulties because she did not have her birth certificate. She again contacted the council and was informed there were no birth records in existence for her at the council.

In 2004, Ms P instructed counsel with a view to taking action against the council, but she could not afford to proceed. Her solicitors did establish that the council was the adoption agency but the council would not confirm this. It was not until 2006 that the council suggested contacting the relevant magistrates' court. It helped Ms P to do this and she was able to obtain the records held by the court relating to the adoption. It was not until the Ombudsman made enquiries that the council accepted that it was the adoption agent and should have maintained Ms P's records.

Conclusion

It was not possible to establish what had happened to Ms P's file. What the council should have done in 1996 was to confirm that it had taken over responsibility from the previous council and that it should have had the records but they had been lost. It should have apologised for this and provided Ms P with clear advice about where she might find information. The failure to do this had led Ms P to spend 10 years in a fruitless search for her records.

In recognition of this the council agreed to make a payment of £1,500 to cover part of her costs. All of the costs were not sought because some of these related to seeking information from the court which it was considered Ms P would probably have done even if she had had access to the records that the council should have had.

(Case reference confidential)

Adult care services

Introduction

We have selected some cases that demonstrate failures in service provision for people who struggle to request and make full use of services because of physical or psychological problems or learning difficulties.

The cases draw attention to the need to take particular care to communicate effectively with service users and ensure that their difficulties do not prevent them from receiving services that they are entitled to, and that their views are properly taken into account.

Two of the summaries relate to joint investigations carried out with the Health Service Ombudsman and demonstrate the importance of taking responsibility for ensuring proper care is provided.

Failure to consider complaints properly when they are made to councils is also a feature of some of these cases. We are hopeful that the recent changes to adult social care complaints arrangements will enable councils to deal more effectively with complaints.

L8: Care of people with learning disabilities

‘Six Lives’ joint investigation with Health Service Ombudsman – treatment of adults with learning disabilities – standard of care – avoidable death – complaint handling

The complaints

The charity, Mencap, brought complaints on behalf of the families of six people with learning difficulties who died while in NHS or local authority care. The complaints were investigated jointly by the Local Government Ombudsman (LGO) and the Health Service Ombudsman (HSO). Three different local authorities were investigated by the LGO.

Case 1: Mr C – complaint against council H

Mr C, a 30-year-old man with learning disabilities, broke his leg while at a council respite home and later died. The LGO found that council H failed to provide an acceptable standard of care for Mr C, so putting his safety at risk. It contributed to a public service failure that resulted in an avoidable death, failed to live up to human rights principles of dignity and equality, and did not handle Mr C’s parents’ complaint properly.

The Ombudsmen considered that Mr C’s death was avoidable, and that he received less favourable treatment for reasons related to his learning disability. Other bodies involved were criticised by the HSO.

The LGO recommended council H to apologise to Mr C’s parents and pay them £10,000 each (an equal amount to that the HSO recommended that the NHS trust should pay). It should also ensure that provider care plans and risk assessments are properly in place for people receiving respite care commissioned by the council.

Case 2: Mr H – complaint against council B

Mr H, a 61-year-old man with learning disabilities, was living in a residential care home run by council B when he was admitted to hospital with an infection. He was discharged, but later died. The LGO did not uphold the complaint that, when Mr H was discharged from hospital, the staff at the home failed to treat him in accordance with advice from the trust concerning his dietary needs. Some of the complaints against other bodies were upheld by the HSO.

Case 3: Mr W – complaint against council G

Mr W was a young man with profound and multiple learning disabilities who died after a period of deteriorating health, including admission to hospital. The LGO found that arrangements by council G for Mr W’s transition into adult accommodation fell significantly below a reasonable standard, and that some of this was for disability-related reasons. Council G failed to live up to human rights principles of dignity and equality, and failed to respond adequately to the parents’ complaint.

The council had already taken action to implement recommendations for service improvements made by an independent investigator.

The LGO recommended council G to apologise to Mr W's parents and offer to pay £5,000 compensation. It agreed to do so. This was part of a total of £30,000 compensation between all the bodies involved.

The Ombudsmen's investigation

The investigation revealed that:

- there were significant and distressing failures in service across health and social care;
- one person died as a consequence of public service (including council) failure, and it was likely the death of another individual could have been avoided, had the care and treatment provided not fallen so far below the relevant standards;
- people with learning disabilities experienced prolonged suffering and poor care, and some of these failures were for disability-related reasons;
- some public bodies (including two councils) failed to live up to human rights principles, especially those of dignity and equality; and
- many organisations responded inadequately to the complaints made against them, leaving family members feeling drained and demoralised.

The Ombudsmen's views

The LGO said:

"On many occasions basic policy and guidance were not observed, the needs of people with learning disabilities were not accommodated and services were unco-ordinated. The complex factors which led to these failures to protect vulnerable individuals demonstrate the need for stronger leadership throughout the health and care professions – this report is not solely a concern for specialists in learning disabilities."

The HSO said:

"The recurrence of complaints across different agencies leads us to believe that the quality of care in the NHS and social services for people with learning disabilities is at best patchy and at worst an indictment of our society.

"Six Lives ***has highlighted distressing failures in the quality of health and social care services for people with learning disabilities. No investigation can reverse the mistakes and failures but if NHS and social care leaders take positive steps to deliver improvements in services, this may bring some small consolation to the families and carers of those who died."***

Outcome

The Ombudsmen recommended that all NHS bodies and social care organisations in England (including councils) should:

- review urgently the effectiveness of their systems to enable them to meet the full range of needs of people with learning disabilities in their area;
- review urgently the capacity and capability of the services they provide (and/or commission) for their local populations to meet the additional and often complex needs of people with learning disabilities; and
- report accordingly to those responsible for governance of those organisations within 12 months of the publication of the report.

The HSO made further recommendations specific to the Department of Health and to the bodies responsible for regulation of health and social care services.

(Report on complaints 07B06309, 07B06077 & 07B09453 issued jointly with the Parliamentary and Health Service Ombudsman: "Six lives: the provision of public services to people with learning difficulties" was laid before Parliament on 23 March 2009.)

L9: Care of people with learning disabilities

Council withdrew support for adult with learning difficulties living independently – deterioration in her mental health and admission to crisis accommodation – dispute about where responsibility lay prevented proper care planning

Background

This complaint had been dealt with by the council through the adult social care complaints procedure but Mr and Mrs M, who made the complaint on behalf of their daughter, Miss M, were not satisfied with the recommendations made by the council and so complained to the Ombudsman.

The Ombudsman obtained copies of the reports prepared by the council's investigating officer and the independent person and concluded that there was no need to reinvestigate the complaint, but it was necessary to consider whether:

- the decisions on the complaints had taken into account all of the relevant factors;
- what the impact of the council's failings was on Miss M and her parents; and
- whether the remedy suggested by the council was a sufficient response.

What happened

Miss M, who was in her early 30s and had mild learning difficulties, had lived independently for some time; with her older sister until 2003 and then in independent accommodation from 2003. In March 2006 she was told that her case was going to be closed. Within three weeks she had made a request for support to move into a shared flat. By October 2006 she had become extremely anxious and said she was hearing voices. She was referred to a crisis house where she remained until August 2007 when she moved into supported accommodation. During her time at the crisis house her eating disorder worsened and she lost weight.

Mr and Mrs M made a number of complaints about the council's failure to provide adequate support for their daughter. Many of these were upheld by the council after an internal investigation. The council established that there were failings in the way that the two services involved with Miss M had operated, with evidence of poor management, supervision, administration and record-keeping and only a very short period between December 2006 and January 2007 when an attempt was made at joint working. The investigation had also found that several requests from the learning difficulties team to the mental health team for joint assessments were unsuccessful, until a meeting in May 2007 when a joint comprehensive assessment was carried out.

The Ombudsman's conclusions

The Ombudsman's investigator concluded that, in addition to the service failures identified by the council, there were two unfounded decisions taken by the learning difficulties team to close Miss M's case: the first in March 2006, based on out of date information, and the second in February 2007 out of frustration at the lack of assistance from the mental health team.

It was not possible to say that Miss M's move to the crisis house was entirely due to these failures, but there was evidence that the failures meant that she stayed at the crisis house for longer than necessary because there was no care manager between October 2006 and June 2007.
It was also accepted that the council's failures must have put additional strain on Miss M which would probably have contributed to her mental ill health. In addition, while Miss M was at the crisis house, the tenancy of the flat was kept for her and she was required to contribute £4 per week towards the rent and water rates.

In recognition of the failings and the effect on Miss M and her family, the council agreed to:

- give a commitment to providing a long-term care manager to Miss M so that she could feel confident that there was someone she could contact for support when needed;
- approach the health service on Miss M's behalf to obtain assistance for her with her hearing voices and her eating disorder;

- apologise to Miss M and to her parents;
- review its mental health protocol to prevent a recurrence of the difficulties Miss M and her parents suffered;
- ensure that disagreement between different parts of the council are resolved quickly by early referral to heads of service;
- refund any financial loss resulting from the payment of contributions towards rent and rates;
- make a payment to Miss M of £1,000 to help towards a holiday; and
- make a payment to Mr and Mrs M of £500 in recognition of the distress and considerable time and trouble they took in looking after Miss M while she was at the crisis house, and in pursuing the complaint.

(Case reference confidential)

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 case illustrates.

L10: Mental health aftercare

Man discharged from hospital following detention under Mental Health Act – two councils refused to fund aftercare costs

The complaint

Mr C was detained in hospital under Section 3 of the Mental Health Act 1983. When he was discharged in 2000 he required aftercare under Section 117 of the Act. His solicitor complained that two councils wrongly refused to fund his aftercare.

The Ombudsman's investigation

At the time of his admission to hospital, Mr C lived in the area of council M. Because he was discharged to a specialist care facility outside its area, council M refused to meet the cost of Mr C's aftercare. Council W, in whose area Mr C lived following his discharge, also declined to pay for his aftercare on grounds that he had previously lived in council M's area, and because it was not party to his placement. As a result, Mr C had to fund his own aftercare for a prolonged period and incurred legal costs in pursuit of his complaints against both councils.

The Ombudsman's view

The Ombudsman considered that Mr C was 'ordinarily resident' in council M's area at the time of his compulsory admission and so found that council M rather than council W was the authority responsible for funding his aftercare. He criticised council M's lack of involvement in the arrangements for Mr C's discharge from hospital, and commented, "In my view, the council's contribution to the discharge process was both limited and ill-informed."

Outcome

The Ombudsman found maladministration by council M causing injustice to Mr C. He found no maladministration by council W. He recommended that council M should:

- determine and reimburse its share of the cost of Mr C's aftercare to date, with interest at the County Court rate, and discuss reimbursement of the remainder with the relevant health authority;
- undertake the future funding of Mr C's aftercare in conjunction with the relevant health authority for as long as it remained necessary; and
- make a contribution of £1,000 to Mr C's legal costs.

(Report 06B12247-8)

L11: Care for elderly people

Serious flaws in care provision for elderly man – failure to consider client's wishes when placing him in a residential home – monitoring of care home packages

The complaint

A woman complained that a council failed to deal properly with the care needs of her elderly father-in-law, Mr D, after the death of his wife.

What happened

Mr D received a home care package from the council, but there were concerns about the quality of care he received from one of the agencies that the council used. The council failed to ensure that the agency was complying with the care plan.

Mr D was then admitted to hospital. On his discharge, the council failed to undertake a proper assessment of his needs, and he was placed in a residential home against both his and his family's wishes.

While Mr D was in the home, the council assessed him as a permanent rather than temporary resident, and consequently made excessive charges.

The Ombudsman's view

The Ombudsman found serious flaws in the council's care provision for Mr D. He considered that the lack of a proper discharge assessment, and the failure to carry out a further assessment as agreed was maladministration and said: "…this, and the council's dismissive attitude to the family, has caused unnecessary and avoidable distress."

He found that the council failed to consider the man's wishes when placing him in a residential home, and said "Councils have no right to disregard a client's wishes in this manner."

Outcome

The Ombudsman found maladministration causing injustice and the council agreed to:

- improve its monitoring of home care packages;
- improve its assessments of residents on discharge from hospital;
- refund the excessive residential care charges of £11,800.64 levied on the basis that Mr D was a permanent rather than temporary resident;
- pay £600 compensation to Mr D and £200 to his family for the avoidable distress and inconvenience caused; and
- pay £250 to his daughter-in-law for her time and trouble in pursuing the complaint.

(Report 07B07665)

L12: Care for people with mental health problems

Man with mental health problems – failure to provide practical assistance requested – joint investigation with Health Service Ombudsman

The complaint

Mr R had mental health problems, and needed help at a particularly vulnerable time in his life when his grandmother died; with her, his sole means of support and social contact was lost. He was profoundly distressed by the difficulties that he faced as a result, to the extent of wanting to kill himself. He complained about the inadequate support he received from a mental health service that was an integrated service for adults with mental health difficulties provided jointly by a council and an NHS trust.

What happened

Mr R did not find any of the contact he had with the mental health service helpful. He maintained that, despite several assessments, he was offered no practical support to manage in the community, but was left, instead, to struggle to cope on his own. He had specifically sought help with his shopping, as he was agoraphobic, but this help was not provided until he himself felt able to take the initiative in April 2005 and make his own arrangements direct with another department of the council.

The Ombudsmen's view

The complaint was investigated jointly by the Local Government Ombudsman and the Health Service Ombudsman. They accepted that the mental health service did try to support Mr R in the community and accepted the views of the staff involved that he was a difficult patient to engage.

They said:

"He was sceptical about the benefits of psychiatric input, and we appreciate that services cannot – and should not – be foisted on people who do not want them. Nevertheless, he was quite clear in expressing what practical help he required, and yet some four months elapsed before this was provided and then not through the mental health service."

They added:

"Some of the oversights were inexcusable: for example, the mental health service's failure to deal with Mr R's pets and to notice that he had missed his appointments, even when he had warned that he would do so. But there were other omissions too – relying too much on Mr R's apparent rejection of services, when it was clear that he needed practical help; and failing to make sufficiently rigorous assessments of his ability to cope."

Outcome

The Ombudsmen found maladministration causing injustice, and the trust and the council agreed with their recommendations to:

- apologise to Mr R;
- pay him £500 (split between the two bodies) for his distress and his time and trouble in pursuing his complaint; and
- provide an account of service improvements, some planned and some already made, to address the failures identified.

(Report 06C10526)

L13: Care for people with disabilities

Profoundly disabled young man – failure to provide services to him and his family – failure to recognise complaint – council's approach not 'person-centred'

The complaint

Mr S suffered from cerebral palsy and epilepsy and was profoundly disabled. At 21 years old, his parents provided much of his care. His sister complained that a council failed to explain and put into practice policies relevant to his care, with the result that the family did not receive appropriate services from the council.

What happened

The family's MP complained to the council about the lack of service provision for Mr S. Initially the council treated it as a request for a disabled facilities grant, and it took over a year to recognise the complaint for what it was. It was over two years later that the council's own 'stage 3' complaint investigation (carried out by an external investigator) was completed and accepted. The investigator largely upheld the complaint, finding that the council's approach was not 'person-centred'. There were delays in making provision for Mr S, including the provision of a hoist. Because their home was not adapted for Mr S's disability, his father carried his son upstairs to be bathed. The Ombudsman endorsed the criticisms of the council made by the stage 3 investigator, and criticised the delay in completing the process.

The Ombudsman's view

The Ombudsman said that the young man and his family were "in dire straits", and "Mr S's quality of life, and that of his family, was inevitably affected for the worse by the council's approach to his problems. And that is a situation that has persisted, in my view, for some three years longer than necessary."

Because the family did not take their advice, occupational therapists made a referral under the council's protection of vulnerable adults procedures. The Ombudsman found this use of the procedure inappropriate and hurtful to the family, and said "It beggars belief that the referral was made at all."

Outcome

The Ombudsman found maladministration causing injustice and recommended that the council:

- pay the family £15,000;
- review its procedures and practices; and
- provide staff training as appropriate.

(Report 07B07665)