Local Government & Social Care OMBUDSMAN

12 August 2021

Complaint reference:
20 007 910

Complaint against:
Wolverhampton City Council

The Ombudsman's final decision

Summary: Mr C complained the Council failed to investigate his concerns about a change of use, failed to keep him up-to-date and failed to respond to his letter to the Chief Executive. There is no fault in how the Council considered the change of use issues. The Council failed to keep Mr C up-to-date or make clear it had delegated a response to his letter to the Chief Executive to one of its planning officers. That caused Mr C to go to time and trouble to pursue his complaint. An apology to Mr C and reminder to officers is satisfactory remedy.

The complaint

1. The complainant, whom I shall refer to as Mr C, complained the Council:
   - failed to properly consider a change of use of a property close to him;
   - failed to keep him up-to-date during the enforcement investigations; and
   - failed to respond to his letter to the Chief Executive.
2. Mr C says failures by the Council mean he has been deprived of his right to information and consultation.

The Ombudsman's role and powers

3. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. The Ombudsman cannot question whether a Council's decision is right or wrong simply because Mr C disagrees with it. He must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended and 34(3))***
4. If we are satisfied with a Council's actions or proposed actions, we can complete our investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

5. As part of the investigation, I have:

- considered the complaint and Mr C's comments;
- made enquiries of the Council and considered the comments and documents the Council provided.

6. Mr C and the Council had an opportunity to comment on my draft decision. I considered any comments received before making a final decision.

What I found

Use classes

7. The Town and Country Planning (Use Classes) Order 1987 (as amended) puts uses of land and buildings into various categories known as 'Use Classes.' This says residential institutions such as residential care homes, hospitals, nursing homes, boarding schools, residential colleges and training centres are classed as C2.

8. Class C3 covers dwellinghouses and is formed of three parts:

- C3(a) covers use by a single person or a family (a couple whether married or not, a person related to one another with members of the family of one of the couple to be treated as members of the family of the other), an employer and certain domestic employees (such as an au pair, nanny, nurse, governess, servant, chauffeur, gardener, secretary and personal assistant), a carer and the person receiving the care and a foster parent and foster child;
- C3(b) covers up to six people living together as a single household and receiving care e.g. supported housing schemes such as those for people with learning disabilities or mental health problems; and
- C3(c) allows for groups of people (up to six) living together as a single household. This allows for those groupings that do not fall within the C4 HMO definition, but which fell within the previous C3 use class, to be provided for i.e. a small religious community may fall into this section as could a homeowner who is living with a lodger.

9. Class C4 covers houses in multiple occupation. These are small shared houses occupied by between three and six unrelated individuals, as their only or main residence, who share basic amenities such as a kitchen or bathroom.

What happened

10. Mr C lives near a property which was previously used as a residential property. In April 2019 Mr C became aware of changes taking place at the property to provide accommodation for five adults who would each receive support from carers throughout the day and night. Mr C contacted the Council because he believed this meant the property was being developed into a care home which would change the use category.

11. The Council contacted the operator of the property to obtain some information about the proposed use. The Council received some limited information at first which suggested a change of use had occurred. The Council told the operator of the property that was its view. The operator of the property disagreed and provided details of case law which it advised supported its view the property was being used as supported living and therefore fell within the same use class. The

Council visited to inspect, obtained some more information from the operator of the property and took its own legal advice. Following that the Council was satisfied the property remained in the same use class.

12. Mr C had contacted the Council by letter in April, May and August 2019 about the developments at the nearby property. Mr C has also telephoned the Council. In February 2020 Mr C also brought a letter to the Council addressed to the Council's Chief Executive. A planning officer from the Council wrote to Mr C on 5 February 2020, explaining the Council's view that developments at the property did not constitute a change of use. The planning officer referred to Mr C's letters in April, May and August 2019.

Analysis

13. Mr C says the Council failed to properly consider the change of use for the property he complained about. Mr C says the property was previously a C3 use as a residential property. Mr C says because several different people not from the same household are now living in the property and receiving care it should be classed as a C2 property. I set out the use categories relevant in this case in paragraphs 7-9 of this statement.

14. The evidence I have seen satisfies me the Council acted on the concerns Mr C raised by initially advising the owner of the property it considered a change of use had occurred. When the operator disputed that and provided more information I am satisfied the Council properly considered that information by visiting the site to inspect the usage of the property, took legal advice and considered case law. Following that consideration the Council was satisfied the property was being used in accordance with class C3(b) and therefore no change of use had occurred. I recognise Mr C disagrees with that view. However, as I said in paragraph 3, it is not the role of the Ombudsman to comment on the merits of a decision reached without fault. As the Council has properly considered the usage of the property before deciding a change of use has not occurred I have no grounds to criticise it.

15. Mr C says the Council failed to keep him up-to-date with what was happening with its investigation. The evidence I have seen satisfies me Mr C initially contacted the Council with concerns about developments at the property in April 2019 and made further contact by letter with the Council in May and August 2019. It is also clear Mr C telephoned the Council on a number of occasions to obtain an update. It should not be for Mr C to go to time and trouble to have to find out what is happening with a concern he has raised with the Council. The Ombudsman would expect the Council to provide regular updates during enforcement investigations. Failure to do that in this case is fault. As far as I can see Mr C was not given any clear advice about the position the Council was taking in relation to the change of use issue until February 2020. I appreciate the planning issues were complex. However, the documentary evidence shows the Council was taking action on the concerns raised by Mr C in respect of the use of the property. If the Council had told Mr C about the action it had taken this might have satisfied Mr C the Council was taking his concerns seriously. In the absence of any clear advice given to Mr C about what action the Council was taking I am not surprised he felt the Council was not taking his concerns seriously.

16. Mr C says he hand-delivered a letter to the Council's Chief Executive on 3 February 2020 and did not receive an acknowledgement or response. The Council says its normal procedure is for letters to the Chief Executive to be passed to the relevant department for response. The Ombudsman would not

criticise that process and this is a process followed by most councils. However, the Ombudsman would expect any delegated response to make clear the letter has been passed to that person for response on the Chief Executive's behalf.

17. In this case the Council cites the planning officer's letter of 5 February 2020 as its response to the issues Mr C had raised. I accept the Council's letter of 5 February 2020 addresses Mr C's concerns about the property he wrote to the Chief Executive about. However, the Council's letter refers to the points raised in Mr C's previous letters and then lists those letters. That does not include the letter of 3 February 2020. Nor does the letter tell Mr B it is provided as a response to his letter to the Chief Executive. In those circumstances it is not surprising Mr C believed his letter to the Chief Executive had been ignored. Failure to make clear the Council's response of 5 February 2020 was intended partly as a response to Mr C's letter to the Chief Executive and that the planning officer had been asked to respond on the Chief Executive's behalf is fault. That led Mr C to believe his correspondence had not been dealt with and led to him going to time and trouble to pursue his complaint.

18. So I have found fault as the Council failed to keep Mr C up-to-date with what was happening with its enforcement investigation by only providing updates when Mr C contacted the Council, delayed telling them about the outcome of the enforcement investigation and failed to explain the Council's response of 5 February 2020 was also a response to his letter to the Chief Executive. Taking into account my view there is no fault in how the Council handled the issue of whether there had been a change of use I consider Mr C's injustice is limited to the time and trouble he had to go to pursuing his complaint. As remedy I recommended the Council apologise to Mr C. I also recommended the Council remind enforcement officers of the need to keep the person who has complained about planning breaches up-to-date with what is happening during an enforcement investigation. The Ombudsman would consider 4-6 weekly updates satisfactory. The Council has agreed to my recommendations.

Agreed action

19. Within one month of my decision the Council should:

- apologise to Mr C; and
- send a memo to enforcement officers to remind them of the need to provide regular updates during any enforcement investigation to those who have raised concerns.

Final decision

20. I have completed my investigation and found fault by the Council in part of the complaint which caused Mr C an injustice. I am satisfied the action the Council will take is sufficient to remedy that injustice.

Investigator's decision on behalf of the Ombudsman

11 August 2021

Complaint reference:
20 008 211

Complaint against:
Wolverhampton City Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: the complainant says a care provider commissioned by the Council failed to properly manage financial support for the client. The Council said its care provider responded to the complaint, but it had yet to complete a full investigation and offered to do so. We found the Council through its commissioned Care Provider acted with fault and recommended a proportionate remedy.

The complaint

1. The complainant, whom I shall refer to as Mr X complains through his representative Miss Y, that the Council commissioned Care Provider failed to properly tell Miss Y about a hospital visit, account for money withheld from Mr X and continued to accompany Mr X when he made bank withdrawals after the Care Provider's contract had ended.
2. Ms Y says this compromised Mr X's security and welfare and the Council and Care Provider have not answered her complaints or direct her to the Ombudsman's service. Ms Y says ending Mr X's service without warning or appropriate handover caused him significant distress.
3. Ms Y wants the Council and Care Provider to review her complaints, ensure complainants receive information about the complaints procedure with each response telling them about the next steps in that procedure.

The Ombudsman's role and powers

4. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***
5. We investigate complaints about councils and certain other bodies. Where an individual, organisation or private company is providing services on behalf of a council, we can investigate complaints about the actions of these providers. ***(Local Government Act 1974, section 25(7), as amended)***
6. If satisfied with a council's actions or proposed actions, we can complete our investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

7. In considering this complaint I have:

- Contacted Miss Y and read the information presented with the complaint;
- Put enquiries to the Council and reviewed its responses;
- Researched relevant law, guidance, and practice;

8. I shared with Miss Y and the Council my draft decision and considered their comments before reaching this my final decision.

9. Under the information sharing agreement between the Local Government and Social Care Ombudsman and the Care Quality Commission (CQC), we will share this decision with CQC.

What I found

10. Mr X does not have capacity to manage his own finances and in 2012 the Council became his financial appointee. The Council manages the receipt of Mr X's Department of Work and Pensions benefits. The Council pays Mr X's utility bills from this account. Under that arrangement the Council receives the benefits into a bank account held for Mr X his benefits. From that account the Council transfers into Mr X's private bank account each month an allowance for personal spending. Each week to ensure Mr X had enough money for his weekly needs, staff placed money in separate envelopes marked for specific purposes. These included shopping, attendance at the day centre and taxis, and personal use.

11. The Council commissioned 11.45 hours per week support for Mr X from Care Provider Q from November 2018. In May 2020, the Council increased the support to 13 hours. The Council awarded a further 30 minutes a day support as needed to support Mr X during the Covid-19 pandemic lockdown for use during emergencies for example providing support getting medical attention.

12. Support in managing Mr X's finances formed part of the service provided to him by Care Provider Q. The Council says that Miss Y and Care Provider Q agreed in June 2019 that two staff members from Care Provider Q would attend the bank with Mr X to help him withdraw his money. The bank registered the names of the staff who could escort Mr X. In commenting on my draft decision Miss Y says the Care Provider put the arrangement in place and told her, she did not agree it.

13. Under his support plan staff accompanied Mr X to hospital appointments. Usually Care Provider Q would tell Miss Y about these appointments.

14. Care Provider Q's records show that in May 2020 Mr X needed medical support. Care Provider Q's staff helped Mr X call his GP who prescribed antibiotics. Staff collected his medication. Staff developed a rota for seven days to ensure Mr X took his prescribed medication.

15. The Community Nurse assessed a wound on Mr X's back and decided the best treatment would be to leave it uncovered. The Community Nurse said she would get a care plan written up so support workers would know what to do. Care Provider Q's staff say in an email that it would not be in Mr X's best interest to share information about the wound and treatment with Miss Y. Not until the parties agreed a formal information sharing agreement. The email's author said Miss Y did not use information provided to Mr X's benefit.

16. The GP told staff that if at the end of the course of antibiotics prescribed for Mr X, he experienced no improvement they should take him directly to the emergency

department at the hospital. Mr X appeared in pain when staff visited on 8 May 2020. Staff took Mr X to hospital. In the Care Provider's records it says staff acted in Mr X's best interests. The record says *"…at no point was its considered important to discuss the business with anyone else outside of [the Care Provider*]". The notes say however, but for the lockdown restrictions it may have been possible for Miss Y to go with Mr X to hospital. The note ends saying: *"Informing [Miss Y] would have been of no immediate benefit to [Mr X] and [Care Provider Q] in providing the excellent, timely and medically directed support."* In response to my enquiries the Council described this as an oversight by Care Provider Q.

17. On 28 May 2020 Care Provider Q gave notice to both Miss Y and the Council ending the agreement for its support services and saying Mr X needed an alternative service provider.

18. In June 2020 the Council spoke with Miss Y about her concerns about Mr X's finances. Miss Y told the Council she wanted to ensure she protected Mr X against financial abuse and the Council agreed it would speak to Care Provider Q. The Council's records show that on speaking with Care Provider Q, staff said Miss Y had constantly telephoned and messaged them to gather information about Mr X's daily activity plan and his finances. Miss Y disputes this. Care Provider Q said it was reluctant to share information even though it recognised Miss Y as next of kin. The Council decided to meet with Mr X to see if he objected to daily updates being given to Miss Y.

19. The Council arranged a transition meeting at Mr X's home with Miss Y, Care Provider Q and the new care provider, Care Provider Z. The case records say Care Provider Q asked for any handover to be with Care Provider Z or the Council because Care Provider Q did not trust the family. At the handover the key safe would not work with the numbers Care Provider Q had given and the Council asked Mr X's landlord to install a new key safe. The landlord did not so Miss Y paid for a new key safe. Miss Y says lack of action put Mr X at risk.

20. The new service started on 26 June 2020. In August 2020 Miss Y presented a 14-point complaint to the Council about Care Provider Q. Miss Y's complaint covered concerns about the key safe and errors in the handover document. It covered failure to update details of suitable people to escort Mr X to the bank and continuing to withdraw money when Mr X could not attend his day centre. It also includes the failure to tell Miss Y about the hospital visit, and concerns about items missing from Mr X's home.

21. Under arrangements with care providers commissioned by the Council, any complaint about the service will first be considered by the care provider under its complaints' procedure. If that does not resolve the complaint, then the Council will consider it. The Council says Care Provider Q responded to the complaint, but the Council has not completed its investigation. It is willing to do so.

Analysis – was there fault leading to injustice?

22. My role is to consider if in providing the commissioned service and considering any complaints about it the Council and its commissioned service acted without fault. If I find they acted with fault, then I must decide what impact that has had and what the Council should do to address the injustice.

23. Miss Y is recognised as Mr X's next of kin. Therefore, she could expect the Council to consult her under the Mental Health Act should it need to make best interest decisions. Miss Y could also expect the Council's commissioned care

providers to communicate with her about Mr X's health, wellbeing, and finances. Where significant events occur such as the need to go to hospital Miss Y could expect the care provider to tell Miss Y as soon as possible about that visit. There is no supporting evidence for the decision that telling Miss Y about Mr X's visit to hospital was 'unnecessary'. The record does not record any report to the Council or any evidence of safeguarding concerns that would support not telling Miss Y. I find the unsupported decision fault. Further I find the Council's characterisation of the failure as an oversight as fault because the record clearly shows this was a deliberate decision.

24. The record suggests a poor relationship between Miss Y and Care Provider Q. That does not excuse unsubstantiated remarks in the record that Miss Y does not use information given her in Mr X's best interests. I would expect the Council to investigate that comment and to ask for evidence in support of it so it can undertake any necessary safeguarding investigation.

25. I find the failure to follow up the safeguarding concerns raised by the broken key safe as fault. The Council could have considered replacing the key safe at its own cost with the landlord's permission to reduce any risk. The failure to keep the register of approved people at the bank up to date with correct names and to explain why staff helped Mr X withdraw the same money during lockdown when Mr X could not attend his day centre I find as fault.

26. Miss Y has experienced avoidable anxiety and delay to a final review of the issues by the Council. I welcome the Council's offer to fully investigate the complaint with Care Provider Q. I must decide if this is a proportionate response to the complaint and addresses any injustice. I find it does not fully reflect the injustice experienced, particularly the decision to deliberate withhold information.

Agreed action

27. When a council commissions another organisation to provide services on its behalf it remains responsible for those services and for the actions of the organisation providing them. So, although I found fault with the actions of Care Provider Q I have made recommendations to the Council. The Council agrees to within four weeks of my final decision the Council:

- Apologise to Miss Y for the poor service received and delay in investigation;
- Pay Miss Y £150 in recognition of the failings by its care provider;
- Open its investigation into the concerns raised, completing it within sixteen weeks of my final decision and to share its findings with Miss Y, Care Provider Q and its commissioning section and social workers;
- Open a review of its service agreements to ensure care provider's complaints procedures and information set out how a complainant may escalate their complaint within that procedure, take it up with the Council and with the Ombudsman. The review to be completed within twelve weeks of my final decision.

Final decision

28. In completing my investigation, I find the Council at fault causing injustice for which a remedy has been agreed.

Investigator's decision on behalf of the Ombudsman

2 November 2021

Complaint reference:
21 001 484

Complaint against:
City of Wolverhampton Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: We upheld Mr X's complaint about a safeguarding enquiry into his mother Mrs Y's care. The Council has already apologised for the delay in investigating safeguarding concerns. It will make a symbolic payment to Mr X to reflect his avoidable distress.

The complaint

1. Mr X complained City of Wolverhampton Council (the Council) did not take prompt action in response to concerns he raised to a social worker about his mother's (Mrs Y's) carer workers neglecting her in January 2020. He also complained that when action was finally taken, the Council failed to consider relevant evidence demonstrating neglect (recordings and photos). Mr X also complained about a social worker being unprofessional on the phone.
2. Mr X said the Council caused him avoidable distress and placed Mrs Y at continuing risk of neglect.

The Ombudsman's role and powers

3. We investigate complaints of injustice caused by 'maladministration' and 'service failure'. I have used the word 'fault' to refer to these. We cannot question whether a council's decision is right or wrong simply because the complainant disagrees with it. We must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, section 34(3), as amended)***
4. If we are satisfied with a council's actions or proposed actions, we can complete our investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

5. I considered the complaint to us, the Council's response to the complaint, some of Mrs Y's case records and recordings of calls between Mr X and the social worker. I discussed the complaint with Mr X.
6. Mr X and the Council had an opportunity to comment on my draft decision. I considered any comments received before making a final decision.

What I found

Relevant law and guidance

7. If a council has reasonable cause to suspect abuse of an adult who needs care and support, it must make whatever enquiries it thinks is necessary to decide whether any action should be taken to protect the adult. ***(Care Act 2014, section 42)***

8. Care and Support Statutory Guidance, paragraph 14.13 sets out six principles for safeguarding:

- Empowerment: asking the person affected what they want
- Prevention: taking action before harm occurs
- Proportionality: taking the least intrusive response appropriate to risk
- Protection: support and representation for those greatest in need
- Partnership: working together
- Accountability: being open and transparent.

Key facts

9. Mrs Y has dementia and lives in her own home. She has two live-in care workers which the other siblings (not Mr X) arranged and pay for. The Council was not involved in arranging Mrs Y's care. The siblings, including Mr X, hold joint Lasting Powers of Attorney (LPA's) for health and welfare. (The LPA allows the siblings to make decisions about Mrs Y's health and welfare in her best interests.) Unfortunately, the siblings fell out and they do not agree about the care arrangements.

10. The case notes show a social worker visited Mrs Y before the first lock-down and liaised with all the siblings, including Mr X. In January 2020, Mr X told the social worker he had concerns about the care workers including leaving her in the house alone, not taking her out and ignoring her. Mr X also explained about disagreements between him and his siblings over finances.

11. The other siblings told the social worker they were happy to pay for care privately and did not want the Council's involvement.

12. An occupational therapist also assessed Mrs Y, she walked independently and could get to the toilet and get in and out of bed and chairs herself. The occupational therapist recommended some small pieces of equipment.

13. The Council appointed an advocate, who did not visit Mrs Y until September 2020 because of the lock-down. The advocate noted Mrs Y said she would like to live with Mr X at first, but later said she was happy to live in her own home with the care workers because Mr X went out to work and she was being looked after in her home.

14. There were three safeguarding alert forms for Mrs Y in November 2020, which the social worker and other council staff completed from information Mr X provided. I have summarised the alert forms below:

- Care workers not being trained or vetted by the Disclosure and Barring Service (DBS) and about one care worker leaving Mrs Y was left alone on one occasion.
- Care workers were telling Mrs X the wrong time so they could put her to bed early. He also said a care worker was stealing his mother's food.

- General dissatisfaction with Mrs Y's care arrangements and wanted Mrs Y to live with him.
- Medication administration for one dose of an antibiotic in December 2019 and about finding medication in blister packs.
- Mr X said he had reported similar concerns earlier in 2020.

15. The papers also noted there had been a referral for advocacy and Mrs Y's advocate had spoken to her and said that she did not want to live with Mr X and that she was happy with the care workers.

16. Information on one of the safeguarding referral forms indicated the police looked at evidence Mr X had provided and it suggested care workers were telling Mrs Y it was later than it was to get her to go to bed early.

17. The Council started a safeguarding enquiry. It sought information from all family members, from the Police, GP and the Office of the Public Guardian (this is the body which supervises holders of LPA's). The Police took no further action as there was no apparent crime. A social worker spoke to Mr X to discuss his concerns in more detail. He said in December 2019, he visited his mother and there was no carer present for two to three hours. He said he wanted different care workers. A social worker also spoke to one of the siblings who said:
    - They were happy with the care arrangements
    - The care workers spoke the same language as Mrs Y
    - The incident when Mrs Y was left alone was a one-off and the worker had been spoken to
    - There was a clock on the table so Mrs Y could see the time herself and she liked to go to bed early
    - They paid for food for Mrs Y and the care workers from their own money.

18. Mr X provided me with a recording of two phone calls he had with Mrs Y's social worker in November 2020. The discussion was heated at times, but there was no rudeness by the social worker. Mr X's view is the social worker was unprofessional.

19. In February 2021, Mr X spoke to Mrs Y's GP about some concerns. The GP made a safeguarding referral after, which said Mr X had reported Mrs Y's care workers were not trained and were illegal immigrants and had left her to sit in a chair all day. The GP also said Mrs Y had developed pressure sores which the GP had referred to the district nurses to look at.

20. A different social worker carried on with the safeguarding enquiry. Their report of the enquiry noted:
    - Mrs Y's advocate had met with her and established her wish to stay where she was with her care workers.
    - The care worker alleged to be responsible had not been interviewed because they were no longer working for Mrs Y.
    - The district nurse reported they had discharged Mrs Y because there were no pressure sores and no concerns about neglect
    - Family dynamics were strained
    - Another sibling said:

a) care workers were employed through a company. Mrs Y needed prompting and assistance – meal preparation, prompting with medicine and domestic tasks. No particular training was required. They were DBS checked.

b) The incident where Mrs Y was left alone was a one-off due to a misunderstanding about change over times and Mrs Y was safe to be left alone for a short period.

c) The care worker alleged to have given incorrect time and put her to bed early was no longer working. Mrs Y had structured bedtimes.

d) They paid for all the food in the house and care workers were allowed to eat whatever they wanted.

e) Mrs Y was encouraged to wash and change her clothes daily.

f) They could not comment on the medication issues, which were from 2019, but Mrs Y was being supported to take her medicine.

21. In February and March 2021, a social work manager wrote to Mr X to address his complaints saying:

- The social worker contacted each of the parties every time there was a query and would continue to do so
- The care workers' immigration status was not for the Council to deal with because it had not arranged Mrs Y's care
- Issues relating to the quality of care had been raised with the siblings. The social worker had also made safeguarding referrals in November 2020
- Mrs Y met with an advocate alone so the Council could seek her views. It was appropriate that her care worker was there because she knew this person well. The advocate could not prevent the sibling from coming in at the end of the meeting as it was Mrs Y's home. The advocate's report noted Mrs Y changed her mind several times about where she wanted to live and this was before and after the sibling came.
- The social worker should have made a safeguarding referral in January 2020. Enquiries were underway and he would get feedback on the outcome
- A different social worker had been allocated to Mrs Y's case.

22. The conclusion to the safeguarding enquiry was there was no evidence to suggest Mrs Y had experienced harm and other professionals consulted had no concerns. The Council closed the safeguarding enquiry in May 2021. The social worker emailed Mr X to give him feedback on the outcome and informed Mr Y that any of the LPA's could start proceedings in the Court of Protection or they could arrange mediation between themselves if they were unhappy about Mrs Y's care or living arrangements.

23. The Council told me:

- The social worker should have made a safeguarding referral in January 2020 and there was an unacceptable delay. It had already apologised to Mr X and addressed the matter with the social worker. The Council would be willing to offer Mr X £150 to recognise his avoidable distress for the delay.
- Its legal advice was that covert recordings may be a breach of human rights and so social workers had not listened to them

- It made proportionate enquiries to establish facts from different sources. It kept Mrs Y at the centre of the process.
- Mr X made allegations that the siblings considered to be false.
- Some allegations could not be confirmed on a balance of probability as to whether Mrs Y had suffered abuse or neglect. Explanations by district nurses and the other siblings provided a different view or disproved some of the allegations Mr X made. Managing risk and preventing injury to Mrs Y was the priority
- Mr X provided transcripts which were considered.
- The Council was not the Police and safeguarding enquiries were not criminal investigations. The enquiries made were proportionate to the allegations made.
- The dispute between the siblings who all hold LPA caused difficulty and this caused everyone distress.

Was there fault?

24. There was fault by the Council: it delayed in dealing with the concerns Mr X raised in January 2020. The Council has already recognised this and apologised for the avoidable distress to Mr X in its complaint response.

25. There was no fault in the Council's safeguarding enquiry otherwise. The Council has discretion about how to conduct safeguarding and although Mr Y does not agree with the outcome, I am satisfied it dealt with the matter fairly and proportionately in line with the principles described in paragraph eight. In particular, the Council appointed an advocate for Mrs Y, gathered information from different sources, including independent sources and gave feedback to Mr X about the outcome.

26. There was no requirement to seek all possible available evidence and the Council has given a satisfactory reason for not using Mr X's covert evidence: it would have been a disproportionate response to the concerns raised and there were concerns about the privacy of those involved. As I have not found any fault in the safeguarding process (other than the delay already identified), I have no grounds to criticise the outcome.

27. I have listened to the recordings of the calls between Mr X and the social worker. I find there was no fault by the social worker. I do not share Mr X's view that she was unprofessional.

Agreed action

28. In response to my enquiries, the Council suggested a payment of £150 to reflect the avoidable distress to Mr X. This is in line with our Guidance on Remedies and the Council has agreed to make this payment within one month of my final decision.

Final decision

29. I upheld Mr X's complaint about a safeguarding enquiry into his mother Mrs Y's care. The Council has already apologised for the delay in investigating safeguarding concerns. It will make a symbolic payment to Mr X to reflect his avoidable distress.

30. I have completed the investigation.

Investigator's decision on behalf of the Ombudsman

8 December 2021

Complaint reference:
21 008 835

Complaint against:
City of Wolverhampton Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: we discontinued our investigation into Mrs X's complaint that the Council did not offer her suitable fostering placements for a year. Mrs X also complained the Council failed to communicate with her when a child placed in her care went missing. The Council has offered a remedy which Mrs X has accepted, and the other part of her complaint is late.

The complaint

1. Mrs X complained a looked after child went missing from her care in July 2020 and the Council did not contact her to provide an update for four days, which caused her anxiety and distress. Mrs X says since then the Council failed to follow its policies about arranging suitable placements, so she has lost her carer's salary.

The Ombudsman's role and powers

2. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended).***

3. We cannot investigate late complaints unless we decide there are good reasons. Late complaints are when someone takes more than 12 months to complain to us about something a council has done. ***(Local Government Act 1974, sections 26B and 34D, as amended).***

4. We can decide whether to start or discontinue an investigation into a complaint within our jurisdiction. ***(Local Government Act 1974, sections 24A(6) and 34B(8), as amended).***

How I considered this complaint

5. I have discussed the complaint with the complainant and considered the complaint and the copy correspondence provided by the complainant. I have considered the documents the Council provided. Mrs X and the Council had an opportunity to comment on my draft decision. I considered their comments before making a final decision.

What I found

6. Mrs X complained that the Council failed to offer suitable child placements, in accordance with its policies for a year from June 2020. Offers were made, but Mrs X said the Council did not ensure all the placements were properly matched. These issues were ongoing when Mrs X complained to the Council in July 2021, so we do not consider this part of the complaint to be late.
7. The Council responded to Mrs X's complaint, and it has now offered a remedy which Mrs X has accepted.
8. As the Council has offered a suitable remedy and further investigation will serve no useful purpose, I have discontinued our investigation.

Final decision

9. I have discontinued my investigation for the reasons I have explained.

Parts of the complaint that I did not investigate

10. I have not investigated Mrs X's complaint about the actions of the Council in July 2020, when a child she was fostering went missing from her home. Mrs X did not complain to the Council until July 2021, then came to the Ombudsman in September 2021. Therefore, as described at paragraph 3, this part of the complaint is late.
11. We have discretion to set aside this restriction where we decide there are good reasons. In this case we have decided not to exercise discretion. It was reasonable to expect Mrs X to complain to the Council or to us sooner. Mrs X has not provided good reasons why she did not complain to us within 12 months of knowing about the issue.

Investigator's final decision on behalf of the Ombudsman

Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against Wolverhampton City Council (reference number: 19 011 134)

3 June 2021

The Ombudsman's role

For more than 40 years the Ombudsman has independently and impartially investigated complaints. We effectively resolve disputes about councils and other bodies in our jurisdiction by recommending redress which is proportionate, appropriate and reasonable based on all the facts of the complaint. Our service is free of charge.

Each case which comes to the Ombudsman is different and we take the individual needs and circumstances of the person complaining to us into account when we make recommendations to remedy injustice caused by fault.

We have no legal power to force councils to follow our recommendations, but they almost always do. Some of the things we might ask a council to do are:

- apologise
- pay a financial remedy
- improve its procedures so similar problems don't happen again.

Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

Key to names used

Miss B	The complainant

Report summary

Children's Services: adoption

The complainant, who we shall refer to as Miss B, complained the Council declined her request to register as a potential adopter.

Finding

Fault found causing injustice and recommendations made.

Recommendations

To remedy the injustice caused, the Council should review its adoption recruitment procedure to ensure it adheres to the Department of Education's 2013 statutory guidance on adoption.

The complaint

1. The complainant, who we refer to as Miss B, complained the Council declined her request to register as a potential adopter. Miss B said this stopped her from adopting a child.

Legal and administrative background

The Ombudsman's role and powers

2. We investigate complaints about 'maladministration' and 'service failure'. In this report, we have used the word 'fault' to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. We refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***

3. We investigate complaints about councils and certain other bodies. Where an individual, organisation or private company is providing services on behalf of a council, we can investigate complaints about the actions of these providers. The Council commissions a regional adoption agency to deliver adoption services including recruiting adopters so the agency is acting on behalf of the Council. ***(Local Government Act 1974, section 25(7), as amended)***

4. Under the information sharing agreement between the Local Government and Social Care Ombudsman and the Office for Standards in Education, Children's Services and Skills (Ofsted), we will share this decision with Ofsted.

Legislation and Guidance

5. Councils must have regard to the Department for Education's 2013 statutory guidance on adoption when carrying out duties relating to the adoption of children and the recruitment and support of adopters in England.

6. An adoption agency should respond impartially to requests for information about becoming an adopter and provide this within 10 working days through an information session, a visit, pre-planned telephone call or similar arrangement with the potential adopter.

7. Potential adopters need to formally register their interest with an adoption agency to enter stage one of the approval process.

8. The agency should decide within five working days from receipt of a registration of interest form whether to accept this, unless there are exceptional circumstances which mean that longer is needed.

9. The agency may need to arrange a visit or have a meeting or a pre-planned telephone call with the prospective adopter to decide whether to accept their registration of interest.

10. The agency must assess a prospective adopter's ability to parent and meet the needs of a child throughout childhood.

11. Where an agency declines a registration of interest it should provide the prospective adopter with a clear written explanation of the reasons why.

12. Stage one of the procedure starts when the agency accepts the registration of interest to adopt.

Adoption agency procedure

13. The Council commissions a regional adoption agency to deliver adoption services including recruiting adopters.

14. The Council did not provide its or the adoption agency's policies or procedures in response to our enquiries. Below are extracts from the adoption agency's website.

> *"The first step is to get in touch with us. We'll invite you along to one of our information events where you will have the opportunity to meet the team and have your questions answered."*
>
> *"A social worker will visit you for an initial assessment. This visit will go into much more detail than the previous phone conversation, finding out information regarding your background, family history, health, home and work life. The most important thing is to be honest. If you're happy to take your next steps in adoption, we will ask you to complete a Registration of Interest form so we can move on to stage one."*

How we considered this complaint

15. We produced this report after examining relevant files and documents and discussions with the complainant.

16. Miss B and the Council commented on confidential draft reports. We considered their comments before finalising the report.

17. We met with representatives from the Department for Education.

What we found

What happened

18. This chronology includes key events in this case and does not cover everything that happened.

19. Miss B attended an information event with the adoption agency.

20. Miss B then made an enquiry of the adoption agency. In May 2019, a social worker from the adoption agency visited Miss B at home to complete an initial assessment. Miss B shared the report of an initial adoption home visit completed in 2012 and a fostering assessment from 2015 with the social worker.

21. In its initial assessment the adoption agency considered Miss B's background, support network, employment status, experience with children and attitude to parenting. The report identified Miss B's strengths and vulnerabilities.

22. The adoption agency contacted Miss B in June 2019 to apologise that it had not sent her its outcome letter and initial assessment. It told her it had decided she would not be able to proceed with the assessment process for adoption.

23. The adoption agency confirmed its decision in writing in July 2019. It included a copy of her initial assessment report which explained the reasons for its decision were:

- Miss B had limited childcare experience with the age of child she wanted to adopt;

- Miss B had terminated a foster care placement because she could not manage the child's behaviour and the service could not be confident she would be able to manage the complex needs of an adopted child;
- the last time she registered an interest to adopt, it was recommended she sought more childcare experience with young children, but she had not done so beyond one fostering placement; and
- Miss B's financial position was not clear.

24. Miss B complained in October 2019, that:

- the social worker who visited her in May 2019 only stayed 45 to 50 minutes and spent most of that time reading reports; and
- the social worker's manager had delayed responding to her.

25. The Council wrote to Miss B and told her it had not upheld her complaint. It explained the adoption agency's social worker felt she had enough information to make an assessment. The Council included its response to her MP which summarised the reasons it did not accept her registration of interest.

26. Miss B told the Council she was unhappy with its response in November 2019. The adoption agency invited Miss B to a meeting to discuss her complaint which was held in December 2019. The adoption agency explained the factors that led to its decision not to progress Miss B's enquiry to adopt. The agency recommended Miss B gain more experience and develop her insight into the complexities of children who are considered for adoption. The agency explained Miss B could make another enquiry in 12 months. Following the meeting, the Council told Miss B it would investigate her complaint at Stage 2.

27. The Council responded at Stage 2 in January 2020. It said the social worker felt she had enough information to make an assessment and did not uphold this part of Miss B's complaint. The Council accepted there were delays in communicating with her and apologised.

28. Miss B complained to the Ombudsman. We investigated and our draft decision found fault in the process followed by the Council as it should not have done the assessment until she formally registered her interest with the adoption agency.

Council response

29. The agency challenged our provisional finding that it had not followed statutory guidance. It advised its procedure:

> *"… is routine and common practice for all adoption services and is fully compliant with the regulatory guidance and the criteria against which Ofsted inspect adoption services … Department for Education are fully aware and supportive of this approach."*

30. This information was misleading. The agency later admitted the Department for Education had not sanctioned this practice:

> *"An initial conversation has taken place (verbally) with the Department for Education who have indicated that they are willing to consider this, albeit, further discussion and consideration is needed."*

31. Although the Council has explained there was no intention to mislead, we remain disappointed the agency misrepresented its communications with the Department for Education in an attempt to absolve itself of fault.

32. The Council told us that its recruitment procedure is routine and considered best practice for all adoption services, and this has been the case since the introduction of the Department for Education's 2013 statutory guidance on adoption. It provided comments from the Council for Voluntary Adoption Agencies (CVAA) confirming it was common practice for member agencies of CVAA to adopt a similar approach. CVAA considers this practice necessary to identify obvious difficulties at the earliest opportunity thereby reducing distress and preventing applicants undertaking the considerable efforts required to complete a registration of interest with little prospect of success.

33. After receiving our draft findings, the Council met with the Department for Education to discuss this matter and proposed changes to the statutory guidance. It told us the Department for Education would consider whether the proposed changes could be implemented. The Council said this could result in the Department recommending a consultation exercise be undertaken, but this would be subject to Ministerial approval. It said it was important to understand any changes to regulations or statutory guidance, if agreed, would take time to implement.

34. We met with the Department for Education. The Department confirmed the Council and other Regional Adoption Agencies had asked it to consider changes to the statutory guidance on adoption to allow the practice currently being followed by the Council. The Department said it considered the request and confirmed the guidance would not be amended.

35. Since we issued our draft findings, the Council says it has changed its practice. It says it now tells people that any checks it makes prior to them registering their interest will not prevent them from doing so.

Conclusions

36. The adoption agency visited Miss B in May 2019 before she formally registered her interest to adopt. The Council used this visit to assess Miss B as a potential adopter. This was fault. The agency should not have undertaken an assessment of Miss B until she formally registered her interest with the adoption agency. This caused Miss B an injustice. She lost the opportunity to discuss her interest to adopt within the statutory procedure and believed the assessment had been pre-determined.

37. The agency's website confirms its procedure is to complete an initial assessment before allowing an individual to formally register their interest to adopt. This procedure does not adhere to the Department for Education's 2013 statutory guidance on adoption. The guidance says the initial assessment should take place after someone has formally registered their interest. The agency's procedure gatekeeps who can register their interest to adopt and circumnavigates the statutory time frames for assessment.

38. The Council accepts it was not following statutory guidance. It explained this was because of resource constraints:

> *"With high levels of enquiries and limited staff time, 5 days is not sufficient (following receipt of ROI) to undertake the initial screening visit effectively (which takes 2 to 3 hours of social work time) then write the report and make a management decision about accepting it or not."*

And concerns about raising the expectations of individuals and the impact on recruitment:

"Initial screening prior to ROI avoids this increased expectation and the consequent sense of disappointment and grievance. Declining high numbers of people during the stage 1 process would give a negative message and contradict the 'You Can Adopt' campaign message."

39. As our 2018 focus report, 'Under pressure – the impact of the changing environment on local government complaints' states, while we understand the challenges councils face, resource restraints do not justify a council deviating from legislation, statutory guidance, policies and procedures.

40. The Council said inviting individuals to register their interest would raise expectations. Again, this is not a cogent reason for deviating from the statutory guidance. If the adoption agency provided details of the correct procedure on its website and at its information evenings, individuals would know what to expect.

41. The Council also suggested that following the statutory guidance may compromise authorities' abilities to comply with other critical legal responsibilities and ultimately harm the best interests of children. We have not seen any evidence to support these concerns and it appears to be an attempt to provide post hoc justification for its decision to depart from the requirements set out in the guidance.

42. The Council was at fault for not having due regard to the Department for Education's 2013 statutory guidance on adoption. The Council maintains its approach reflected best practice and is replicated nationwide. However, the Department for Education confirmed the statutory guidance will not be amended and the Council has since altered its practice.

43. There was a significant difference between what the guidance said should happen when a potential adopter wishes to register their interest and what happened in this Council, and potentially nationwide. That is an untenable situation and reinforces why it is appropriate to issue a report in this case. There is an anomaly between the guidance and practice which needs to be addressed.

Recommended action

44. When a Council arranges for another organisation to provide services on its behalf it remains responsible for those services and for the actions of the organisation providing them. So, although we found fault with the actions of the adoption agency, we made recommendations to the Council. Issuing this report and publicly confirming the Council was at fault, alongside the apology previously given for poor communication will remedy the injustice caused to Miss B.

45. The Council should review its adoption recruitment procedure to ensure it adheres to the Department of Education's 2013 statutory guidance on adoption.

46. The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council must consider the report at its full Council or Cabinet and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

Final decision

47. We have completed our investigation into this complaint. There was fault by the Council.

05 May 2021

Complaint reference:
20 001 484

Complaint against:
Wolverhampton City Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: There is evidence of fault by the Council in the way it dealt with a safeguarding investigation about the quality of domiciliary care provided to Mr Y. The Council is also at fault for wrongly informing Mr Y's son to complain directly to the Care Provider, as a commissioner of the care, it the Council that was responsible for dealing with complaints about the care.

The complaint

1. Mr X complains about the standard of domiciliary care provided to his father, Mr Y, by CRG Homecare. The care was commissioned by the Council.
2. Mr X is dissatisfied with the process and outcome of a safeguarding investigation about the above matter.

The Ombudsman's role and powers

3. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***
4. We investigate complaints about councils and certain other bodies. Where an individual, organisation or private company is providing services on behalf of a council, we can investigate complaints about the actions of these providers. ***(Local Government Act 1974, section 25(7), as amended)***
5. If we are satisfied with a council's actions or proposed actions, we can complete our investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

6. I have:
   - considered the complaint and discussed it with Mr X;
   - considered the correspondence between Mr X and the Council, including the Council's response to the complaint;
   - made enquiries of the Council and the Care Provider and considered the responses;

- considered relevant legislation;
- offered Mr X and the Council an opportunity to comment on a draft of this document, and considered the comments made.

What I found

Relevant legislation

7. The Care Act 2014 is the legislation that sets out local authorities' powers and duties in respect of adult social care. The Care Act places a duty on local authorities to promote the wellbeing of people in their area.

8. Sections 9 and 10 of the Care Act require local authorities to carry out an assessment of any adult who appears to need care and support. Where a local authority has determined that a person has eligible needs, it must meet those needs.

9. In some circumstances, a local authority may commission another organisation to provide care services on its behalf. However, it remains responsible for those services and for the actions of the organisation providing them.

10. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 applies to care providers. The Care Quality Commission (CQC) monitors, inspects and regulates adult care services providers to ensure they meet fundamental standards of quality and safety

11. A council must make necessary enquiries if it has reason to think a person may be at risk of abuse or neglect and has needs for care and support which mean they cannot protect themselves. It must also decide whether it or another person or agency should take any action to protect the person from abuse or risk. (s42, Care Act 2014).

12. The Care and Support Statutory Guidance identifies six key principles underpinning all adult safeguarding work: empowerment; prevention; proportionality; protection; partnership; and accountability.

Background

13. Mr Y has dementia and physical health issues and is described as frail and vulnerable. At the time of the complaint, he lived in his own home and received domiciliary care from CRG Homecare (the Care Provider), which he had received since 2017. Mr Y was deemed to have capacity to make decisions about his care and where he lived.

14. The Council reviewed Mr Y's care in December 2017 and in September 2018, the records show Mr Y to be satisfied with the care provided, and that he enjoyed a good relationship with his regular carer.

15. In 2019, Mr X had concerns about the quality of care provided and reported this to the Council. The Council confirms Mr X's complaints and says it initially told him to complain directly to the Care Provider.

16. The records show Mr X complained to the Care Provider in August 2019 about:

- *Lack of response from Branch Manager when raising issues*
- *Wiltshire farm food deliveries not placed in the freezer, just in fridge for care workers convenience*
- *Double ups – Moving & Handling not appropriately carried out – causing pain to the customer when hoisting*

- *Concerns around a grade 3 pressure sore*
- *A year and a half ago it was discovered that a Care Worker had been living at the Service Users home*
- *The Care Workers have called the son during the night saying that they have been unable to move his father and need assistance*
- *When two staff attend the property, only 1 Care Worker actually works, the other has been seen playing with their mobile phone*
- *The Care Workers are quick to leave the property once the time is up*
- *The OT was going out 16.08.19 to show the Care Workers once again how to use the Rotunda/straps etc.*

17. The Care Provider responded to the complaint on 16 August 2019. I have seen a copy of the response, which for the most part, upholds Mr X's complaint. The author of the letter, a regional director of the company, set out the steps the company intended to take to address the issues and improve the quality of care provided to Mr Y. He confirmed the district nurse would continue to support with a grade 3 pressure sore. The director concluded by assuring Mr X he would contact him again in 6-8 weeks to arrange a meeting to discuss the care and support and the improvements made.

18. In September 2019, the Council arranged a multi-disciplinary meeting at Mr Y's home to review his care. Mr X was present along with Mr Y's GP, the allocated social worker, the Care Provider, an occupational therapist, a tissue viability nurse, and an NHS Clinical Commissioning Group assessor. The notes of the meeting show Mr Y had a grade 4 pressure sore and the tissue viability nurse raised concerns about bacteria in the wound. Concerns were also raised about the air pressure in Mr Y's air mattress being switched off. Mr X's dissatisfaction with care workers and the district nurses was noted.

19. The Council reassessed Mr Y's care needs in September 2019. Mr X was present. Mr Y was deemed to have capacity to make decisions about how his care needs were met. The assessor recorded Mr Y's health had recently declined following a fall at home, and that he was being cared for in bed. It was noted that Mr Y had a '*potential grade 4 pressure area'* which the district nursing team were attending to. Both Mr X and the Care Provider expressed concern that the pressure area appeared to be deteriorating. An occupational therapist confirmed Mr Y had a progressive illness. The assessor recorded that should Mr Y's condition continue to deteriorate he may require a residential care placement. It was Mr Y's expressed wish to remain at home for as long as possible.

20. The Council's records show Mr X contacted its duty team on 15 October 2019 to report that someone had raised Mr Y's bed carelessly, thus knocking a shelf off above the bed, ripping out wall plugs and brackets and that £1000 worth of ornaments on the shelf were broken. The broken items had been pushed under the bed and Mr X had not been informed. Mr X said he had reported this to the Care Provider and the district nursing team.

21. The Care Provider responded to Mr X in writing on 1 November 2019 to say it had investigated his concerns and had found no evidence that damage to Mr Y's property had been caused by care workers. In relation to the complaint about a care worker living in Mr Y's home it said, this was **"...***a historical concern and was investigated and concluded previously, therefore I will not be re-investigating this*

point. You will be aware that the staff member in question, no longer works for CRG Homecare".

22. On 29 October 2019, whilst Mr X waited for an ambulance to transport Mr Y to hospital, he telephoned the Council and alleged Mr Y had been subject to poor care and neglect by the Care Provider and district nurses. He asked the Council to investigate his concerns under safeguarding. He also reported that a carer had spilt hot tea on Mr Y whilst the ambulance staff were in attendance, that the ambulance staff asked carers to change his top, but they left without doing so. The Council recorded Mr Y's concerns and completed a MASH referral (multi-agency safeguarding hub) on 1 November 2019.

23. When Mr Y arrived at hospital he was examined by a doctor, the doctor subsequently contacted the Council to raise a safeguarding alert. The Council completed a second MASH referral form. The referral form records the concerns to be a duplicate of those raised in a letter written by Mr Y's GP.

24. The Council instigated initial safeguarding enquiries on 1 November 2019. I have seen a copy of the enquiry document. The council officer noted the concerns, that either the carers or district nurses had broken a radiator behind Mr Y's bed and afterwards Mr Y complained of feeling cold. Mr X says it was some days before he discovered the radiator was broken. Mr X also complained about the damage to a shelf above Mr Y's bed and the consequential damage to expensive ornaments. He said the ornaments had been pushed under the bed and he was not told about it. Mr X said he had reported this to the Care Provider, but it denied any knowledge of it.

25. Mr X also complained that carers had switched off the air pressure on Mr Y's air bed. He also said carers left Mr Y lying on a plastic apron because they had run out of incontinence pads. Mr Y had a bedsore; and when he soiled himself, faecal matter had got into the wound.

26. Mr X alleged carers were emptying the contents of Mr Y's catheter bag down the kitchen sink and were reusing single use catheter bags.

27. Mr X also reported some of Mr Y's possessions had gone missing, including money, a clock, a rifle gun, and a large knife. Mr X said Mr Y was reluctant to report the lost items to the police.

28. Mr X reiterated his previous complaints about carers not properly thawing or heating up frozen meals. Carers were heating the meals for 3 minutes as opposed to 11 minutes as advised in the cooking instructions, and this placed Mr Y at risk of food poisoning. He also said a carer had stayed overnight at Mr Y's property and eaten his food.

29. The 'safeguarding enquiry' form noted Mr Y was in hospital and therefore not at risk on ongoing harm, but that the issues raised may impact on other vulnerable people receiving services from the Care Provider and the district nurses. The action plan set out the next steps the Council would take, which included, speaking with Mr X and Mr Y, speaking to, and gathering information from the Care Provider, obtaining records from the district nurse And, involvement of the police if the allegations were of a criminal nature.

30. The Council wrote to Mr X on 13 November 2019 responding to his concerns and said he should raise some of issues directly with the Care Provider. These included:

- damage to Mr Y's personal furniture

- missing personal possessions
- damage to a shelf and resulting damage to a radiator pipe and damage to expensive ornaments
- carers not thawing/heating meals as per the cooking instructions
- carers emptying catheter bags down the kitchen sink.

31. It said complaints relating to a carer standing on Mr Y's foot and laughing it off, and a care worker staying at Mr Y's property were historical matters that had been dealt with previously.

32. The Council said Mr X's other complaints were subject to a safeguarding investigation, and when that process was complete he would receive be notified of the outcome.

33. The Council concluded its initial enquiries on 20 November 2019 and referred the matter for a section 42 safeguarding investigation.

34. I have had sight of the safeguarding documents. The investigating officer noted Mr Y had been discharged to residential care on 11 November 2019, that he would not be returning home and the placement was funded by NHS continuing healthcare. The officer gave an overview of the care Mr Y had received from the Care Provider from 2016 onwards, that it increased and decreased as Mr Y's needs fluctuated. Overall, the care package appeared to be going well, there appeared to be no concerns until 2019.

35. The investigating officer asked the Care Provider and the district nursing service to investigate the allegations and provide a written report.

36. The investigating officer later discussed the allegations with the Care Provider. I have seen a copy of the notes of that discussion. The Care Provider said Mr X's complaint about a carer living at Mr Y's property happened some years previously and had been dealt with at the time. The Care Provider said Mr X had taken over the ordering of Mr Y's incontinence pads and was not reliably ordering them. It acknowledged that carers had placed Mr Y on a plastic apron because there were no incontinence pads available.

37. The investigating officer visited Mr Y at the hospital on 5 November 2019 to discuss the safeguarding allegations and seek his views. The officer asked Mr Y if he wanted to involve the police in relation to the allegations of theft and damage to his property. Mr Y was clear he did not.

38. The investigating officer visited Mr Y in hospital again on 15 January 2020. Mr Y reiterated his wish not to report the missing and damaged property to the police. He wanted the Care Provider and district nurse to reimburse him £1000 but both refused. Mr Y also said he "*I don't know why I should pay for such an appalling level of care when I brought to the social worker and her manager's attention so many times that we were so unhappy with them (care agency) and nothing was done".*

39. The investigating officer received the Care Provider's report on 30 January 2020. He considered it inadequate as it did not address the main concerns. The officer contacted the Care Provider to ask it to reconsider the report.

40. The investigating officer noted "…*the daily records from the Care Agency left a lot to be desired and only October 2019 was available for me to examine…Care Agency's regional manager again as he has not responded to my email requesting further evidence".*

41. The investigating officer also met with Mr X on 5 February 2020 and together they looked through Mr Y's care records.

42. The officer received a report from the district nursing service in February 2020. It confirmed it had identified areas of practice that required improvement and that it had developed an action plan to address this.

43. Mr X said he also believed Mr Y should not have to pay for poor quality homecare, that Mr Y should be compensated, and that he believed the poor quality of care to be the cause of Mr Y's deteriorating health which led to his admission to hospital and subsequently to residential care. The officer advised Mr X to seek legal advice in relation to any financial claim.

44. Following the discussion between Mr X and the investigating officer, a manager from the Council wrote to Mr X to advising him of the options open to him should "...*he wish his stated outcome of financial recompense from the Council. [Mr X] sent same information again into CWC Complaints Dept. Case discussed with Complaints Dept who will seek advice about how Complaints Dpt need to respond to [Mr Y's] son claim for compensation".*

45. The records show Mr X contacted the Council on 22 March 2020 to say he had contacted the police and had been advised to obtain a copy of the safeguarding report. The officer advised Mr X he would inform the investigating officer.

46. In response to the Ombudsman's enquiries, the Council says the Care Provider had been responsible for the provision of pads since the start of their service, but it started to run into difficulties and misunderstandings occurred when Mr X decided to take over the ordering of the pads. Mr X refutes this and says he has never assumed this responsibility. He says an employee at the Care Provider went on holiday and forgot to order the incontinence pads.

47. The investigating officer acknowledged that carers had been using plastic aprons to protect Mr Y's bed and this had exacerbated his pressure sore. The officer recorded that the allegations of emptying catheter bags down the sink and cooking/thawing of food remain '*unexplained'.*

48. In April 2020, the Council's records show the investigating officer received the report from the district nursing service and sought further advice from a nurse.

49. Notes from the investigating officer's supervision with his line manager, record *"Difficult to get more information from care agency -- not sure that it would change outcome – [investigating officer] to go through current evidence -- and in light of Covid restrictions -- to come to a conclusion and complete Enquiry".*

50. The records show a delay in the 'writing-up' of the safeguarding enquiry due to pressures caused by the Coronavirus.

51. The safeguarding investigation report was completed on 19 June 2020. The outcome recorded Mr Y was no longer not at risk of abuse/neglect because he was in permanent residential care, and *"Concerns have been looked into by care agency and District Nurses. Some of the concerns raised about the care agency are historical and have already been addressed by the care agency, more recent concerns also addressed and feedback provided to [Mr Y's] son by the care agency. District Nurses investigation included an Action Plan to address learning outcomes".*

52. The Council received a letter from the Care Provider on 7 September 2020. The author of the letter, a director of the company, confirmed the company had been

notified of the outcome of the safeguarding investigation on 19 June 2020 and confirmed its procedures *"…for dealing with these types of concerns…".*

The Council wrote to Mr X on 10 September 2020 with a response to his complaint, and to inform him of the outcome of the safeguarding investigation. I have seen a copy of this letter. The author, a senior council officer responded to the points Mr X raised.

53. In response to the ordering of incontinence pads, and the complaint that Mr Y was left lying on a plastic apron and faecal matter had got into his bed sore, the officer said, "*There is a documented conversation from 12 November 2019 with the Council's Social Work Unit Manager and [employee] (then CRG branch manager). The conversation stated that you had requested to order all incontinence pads. Unfortunately, due to the time that has lapsed it is difficult to establish when this occurred, and who was responsible for orders. In addition, CRG had reported that your father's bedding was soiled more frequently and had, on occasion, placed an apron to prevent the bedding being soiled".*

54. The officer went onto say "*As part of the Safeguarding, Royal Wolverhampton Hospital Trust (as named at the time) conducted their own investigation and found a number of areas to improve the practice of district nurses. I am unable to comment further on this plan as the Council are not responsible for this element".*

Analysis

55. When local authorities commission care services for a person they remain liable for the service failures of the service provider. So even though Mr X complains about the care agency for the most part the Council is vicariously liable for the faults of the care agency.

56. Councils are the lead agency in a safeguarding investigation and co-ordinate a multi-agency approach, through which early decisions are made about the seriousness of issues raised.

57. When Mr X first complained to the Council about the care provided to Mr Y, it told him to complain directly to the Care Provider. This was incorrect advice. As a commissioner of the care, the Council was responsible for Mr Y's care, and for dealing with any complaints about it. The Council is at fault here.

58. It was only after Mr X was admitted to hospital and safeguarding alerts were made by professionals and Mr X that the Council instigated safeguarding enquiries.

59. The Council records show that it made enquiries with the Care Provider, the district nursing service, and the Police. The Council recognised the Care Providers records were insufficient and contacted it again to request further evidence. When this was not forthcoming it abandoned its efforts, believing that, even if it were to obtain the information it was unlikely it would change the outcome of the safeguarding investigation. The Council should have pursued the Care Provider for the information requested. This is fault by the Council. It should have been concerned about the lack of records and the possibility of general poor record keeping with a wider impact on other service users.

60. During the safeguarding investigation, the Council failed to notice the Care Provider's contradictory complaint responses to Mr X. The complaint response dated 16 August 2019 upheld Mr X's complaint and sets out the steps the Care Provider intended to take as a result. The second complaint response dated 1 November 2019 refutes Mr X's allegations and did not uphold the complaint. Such

inconsistency should have been a cause for concern for the Council, and it should have pursued this further.

61. There was objective evidence of poor care by the Care Provider. For example, the Care Provider acknowledged it used plastic aprons as an incontinence barrier to protect Mr Y's bed. The safeguarding investigation failed to acknowledge this. It also failed to properly address the issue about the supply of incontinence pads. The Council confirmed this was the responsibility of the Care Provider, but it accepted the Care Provider's explanation that Mr X had assumed this responsibility. I have seen no evidence which shows Mr X agreed to take over the ordering of incontinence pads. On balance I find in Mr X's favour. I cannot see why he would fail to order incontinence pads, not doing so would have been detrimental to his father's comfort and would increase the amount of laundry he was doing.

62. The safeguarding investigation concluded Mr Y was not at risk of ongoing abuse/neglect because he was in residential care. Whilst the risks to Mr Y were removed, the Council failed to consider the risks posed to other vulnerable service users from poor care practices. The Council should have overseen the implementation of a robust action plan to improve the quality of care provided by the Care Provider.

63. Mr Y has a progressive illness, it was not possible to say a deterioration in his health was a direct consequence of the care provided. However, at the very least Mr Y would have suffered a significant degree of discomfort due to poor care by the Care Provider.

64. I cannot criticise the safeguarding conclusion in respect of the allegations of theft of Mr Y's personal possessions. The Council is correct, these allegations are of a criminal nature and should be reported to the police. Both Mr Y and Mr X declined to do so.

65. In respect of the damage to Mr Y's property, the damage was not disputed. However, there were conflicting accounts about who caused the damage, the carers and the district nurses blaming each other. Unfortunately, no amount of investigation would establish the facts.

66. Mr X believes the Council should reimburse Mr Y all the contributions he paid towards his care during the period the Care Provider attended him. Whilst it is clear there is some evidence of poor care, the records show Mr Y to be satisfied with the overall care provided between 2017 and 2018.

67. However, I do consider Mr Y suffered an injustice arising out of some poor care by the Care Provider. For this the Council should apologise and make a payment to acknowledge his distress.

68. In relation to injustice caused to Mr X. He has been put to time and trouble pursuing the complaint with the Council and this office. For this the Council should apologise and make a token payment.

Agreed action

69. To remedy the injustice caused the Council should within four weeks of the final decision:

- provide Mr Y with a written apology for the faults highlighted in this complaint and for the distress caused to him and make a payment to him of £1000

- apologise to Mr X for wrongly informing him to complain directly to the Care Provider, and for the way it later handled the safeguarding investigation, and for his time and trouble pursuing this complaint with the Council, Care Provider, and this office. And make a payment to him of £250.

70. Within three months:

- agree a robust action plan with the Care Provider to ensure it addresses the issues of poor care and poor record keeping highlighted in this complaint
- monitor the Care Provider to ensure the improvements are implemented
- seek an explanation from the Care Provider about the conflicting complaint responses provided to Mr X

71. Provide evidence all the above to this office.

Final decision

72. There is evidence of fault by the Council in the way it dealt with a safeguarding investigation about the quality of domiciliary care provided to Mr Y.

73. The Council is also at fault for wrongly informing Mr X to complain directly to the Care Provider, as a commissioner of the care, it the Council who was responsible for dealing with any complaints about the care.

74. The above recommendations are a suitable way to remedy the injustice caused to Mr Y and Mr X.

75. It is on this basis; the complaint will be closed.

76. Under the terms of our Memorandum of Understanding and information sharing protocol with the Care Quality Commission, I intend to send it a copy of the final decision statement.

Investigator's decision on behalf of the Ombudsman

2 August 2021

Complaint reference:
20 006 710

Complaint against:
Wolverhampton City Council

Local Government & Social Care OMBUDSMAN

The Ombudsman's final decision

Summary: Mr C complains about the Council granting a licence to a contractor to lay cabling at night in a residential area. When he complained, the Council's responses minimised the extent of his family's distress. The Ombudsman upholds the complaint. The Council has agreed to our recommendation.

The complaint

1. The complainant, who I refer to here as Mr C, complains:
   - the Council granted a licence for a contractor to install cabling at night in a residential area;
   - in response to his complaint, the Council said the reason it allowed night-time working was to minimise disruption for local businesses. But when the contractors were working in the nearby shopping area, it was only working during the day. So the Council's stated reasons made no sense;
   - the Council's complaint response minimised the extent of the injustice. In fact his family's lives were impacted for around three weeks.
2. As a remedy, Mr C seeks an apology and a payment for the distress.

The Ombudsman's role and powers

3. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I have used the word 'fault' to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'.
4. If we are satisfied with a council's actions or proposed actions, we can complete our investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

5. As part of the investigation, I have:
   - considered the complaint and the documents provided by Mr C;
   - made enquiries of the Council and considered its responses;
   - spoken to Mr C;
   - sent my draft decision to Mr C and the Council and considered their responses.

What I found

Legal and administrative background

6. A company or individual who wants to install and maintain apparatus on a highway needs to apply to a council for a licence under Section 50 of the New Roads and Street Works Act 1991.

What happened

7. The Council issued a permit to a company to lay cables near Mr C's home. The company was a contractor working on a project the Council was involved in.

8. On the first day of work, noise continued past midnight and Mr C emailed the Council to complain. In response to this, and contact from local councillors, the Council agreed with the company the next day that no digging would take place after 11 pm. This did, however, mean the work would take longer to complete than originally planned.

9. Mr C complained again about the noise a few days letter. The Council closed the complaint, as the work was due to end a few days later.

10. About a week later the contractor asked for an extension: it said the works were delayed due to poor weather.

11. A few days later Mr C reported further drilling after 11pm. The Council said it was disappointed and went back to the contractor.

12. Mr C made a formal complaint. He asked the Council to pay him compensation. The Council's response:

    - advised the original decision *"..was to complete works during the daytime. However, due to locality … a high footfall existed. Therefore, an internal decision was taken by the Street Works Team to undertake this works during a late evening and/or overnight*".
    - the works were meant to take 10 days. But after the Council restricted digging to before 11pm, this meant they took longer.
    - it upheld the complaint and sincerely apologised for the contractor's disruption.

13. Mr C asked to escalate his complaint. In response, the Council's records show it was considering a request by Mr C for a £100 payment for his distress. Mr C later deemed this insufficient, so he complained to the Ombudsman.

14. In response to my enquiries, the Council sent me its records of the permit application process. These included applications to vary the process. It was as part of one of these applications, that the Council inserted a condition about the times of work. It has not sent me any contemporaneous record of the internal discussion it says it had when it decided to allow night-time working.

15. Its responses advised:

    - The decision to allow night-time working was to minimise disruption to business on a high street (some earlier daytime work had been carried out for a specific purpose);
    - "*The residential area [where Mr C lives] is a continuation of the commercial area and unfortunately the road was not split for the works due to the nature of the installation required. It cannot have breaks in the ducting or fibre as it would then require street furniture to be installed and would make it difficult to service in the future. On this basis, the permit was applied to the entire length of the [road]".*

- Its Environmental Health team had informally investigated but not taken any formal action.
- "*all overnight works across the city near to residential areas restrict noisy activities beyond 22:00hrs through a standard condition – NCT12a "Noise levels to be kept to an absolute minimum beyond 22:00hrs due to residential area". This condition does not restrict works beyond 22:00hrs, it is merely intended to restrict noisy activities that could disrupt local residents; works can continue through the night in line with the permit."*

Analysis

16. The work was part of a major scheme and I do not consider the Council was at fault in permitting it to take place. It was inevitable it would lead to some noise and disruption.

17. I do have some concerns the Council's records suggest that its first permit allowed overnight working with no consideration of what work was allowable during that time. But the Council acted immediately it received Mr C's complaint about disturbance at night and restricted the hours of work. Mr C did have to make some further contacts, so he was caused further injustice.

18. Considering this history, and with reference to the Ombudsman's Guidance on Remedies, my view is Mr C's original suggestion of £100 is appropriate for his family's avoidable distress. It has already apologised in its complaint response.

19. The Council's response to my draft decision said:

> *"To ensure we learn lessons from this, the council will raise again with* [the contractor] *the importance of the subcontractors being considerate of noise and ensure continued compliance with permits; once the council receives the final report, we will arrange for the financial remedy of £100 to be paid".*

Final decision

I uphold this complaint, due to some fault. The Council has agreed to my recommendation, so I have completed my investigation.

Investigator's decision on behalf of the Ombudsman