Section K: Social services

K1: Adaptations

Delays – relationship with rehousing

1. Mr Pusey had an aggressive and progressively disabling illness. He lost his mobility and used a wheelchair. He and his wife complained that a council delayed in providing aids and adaptations to their home, and that the council did not properly investigate their complaint.

What happened

2. Mr and Mrs Pusey lived in a council-owned maisonette, which was difficult to adapt to meet Mr Pusey's needs. An occupational therapist recommended rehousing in wheelchair accessible accommodation. A property was identified where the ground floor had been partially adapted for wheelchair use. Mr and Mrs Pusey said they would provide a ramp and stair lift. The council undertook to provide central heating, aids and other adaptations.

3. Mr and Mrs Pusey were unable to provide the ramp or stair lift. The council lost sight of the work it had promised. The council considered whether Mr and Mrs Pusey should be transferred to housing association accommodation or whether their new home should be further adapted. It gave Mr and Mrs Pusey confusing advice about Mrs Pusey's security of tenure of housing association accommodation, in the event of Mr Pusey's death. Mr and Mrs Pusey decided not to move and instead to wait for the adaptations.

4. There was confusion over whether Mr and Mrs Pusey's names could be on the waiting list for adaptations and the waiting list for rehousing at the same time. There was a time when their names were on neither list, but eventually the council added their names to the adaptations list. The council's investigation of their complaint, under the statutory complaints procedure for social services, incorrectly concluded that the adaptations and rehousing waiting lists were mutually exclusive.

5. There were long delays by the council in carrying out the work. Some 18 months passed before central heating was installed. There were delays of 14 months in installing grab rails and 13 months in providing a bath lift.

Summary

6. The Ombudsman observed that Mr and Mrs Pusey had to wait longer than they should have done for the adaptations they needed. They often did not know what the council would or would not do for them. The council's communications with them were poor, and internal communications within the council were also poor. It should not have been necessary for Mr and Mrs Pusey to approach the Ombudsman. The council's own investigation was inadequate.

7. The council accepted the Ombudsman's analysis, reviewed its statutory complaints procedure for social services and the way in which it handled requests for aids and adaptations. The council agreed to pay Mr and Mrs Pusey £1,000 in recognition of the effects of the council's faults.

(Report 98/A/322)

K2: Adoption

Prospective adopters – information – delay

1. Mrs Wright complained about the way a council placed two young children (Ben and Alice) with her and her husband with a view to adoption.

2. The children went to live with Mr and Mrs Wright in 1995. Alice was removed from the placement in 1996. Mr and Mrs Wright adopted Ben in 1998.

3. Mrs Wright's main complaints were that the council:

- had not given her and her husband sufficient information to enable them to make an informed decision about the placement;
- had not given them sufficient support during the placement;
- delayed in completing the adoption process for Ben;
- delayed in assessing Ben's special educational needs; and
- did not properly consult her during the process.

4. The Ombudsman upheld all these complaints.

Information

5. The Ombudsman accepted that Mr and Mrs Wright were not given sufficient information about Ben and Alice before the pre-adoption placement. The forms contained insufficient information and made no mention of the children's behavioural problems.

6. The children had been assessed by a child psychiatrist whose report described their behavioural difficulties. The Ombudsman said that before the placement began the council should either have disclosed to Mr and Mrs Wright and the adoption agency the key points of the psychiatrist's report, or should have commissioned a more up-to-date report and disclosed its key findings to them.

7. After the placement began, Mr and Mrs Wright made repeated requests for more information. The Ombudsman accepted that social workers had to make difficult decisions about what they could disclose without improperly breaching necessary confidentiality. Some of the information Mr and Mrs Wright asked for could not be disclosed, but the Ombudsman said that the council did not tell them things which would not have entailed an improper breach of confidence and which they reasonably needed to know, such as information about the children's health and history of abuse.

Support

8. It was agreed between the council and the adoption agency that the council would provide social work support for the children and that the agency would provide support for Mr and Mrs Wright. But, the Ombudsman said, support for Mr and Mrs Wright and for the children had to be considered together. The council was too slow to realise the nature and amount of counselling and other support that Mr and Mrs Wright and the children required.

9. There were unreasonable delays in arranging adequate support after Alice left the placement.

Delay

10. There was muddle and delay in the preparation and submission of the council's report to court for the adoption proceedings in respect of Ben. The delay extended over a six-month period.

11. There was also gross delay in commencing the assessment of Ben's educational needs. The council failed to involve Mrs Wright properly in the process leading up to the issue of a statutory statement of special educational needs.

Injustice

12. The Ombudsman concluded that Mr and Mrs Wright had not been given adequate and timely information to enable them to make a properly informed decision about whether to go ahead with the placement. As it became clear to them that they had not been told enough about the children, they became increasingly anxious about what they did not know. That prolonged anxiety was an important element of the injustice caused by the way the council acted. The anxieties were compounded by the muddle and delay in the preparation of the report for the adoption proceedings and the assessment of Ben's educational needs.

The Ombudsman's comments

13. The Ombudsman observed:

"Adoption often makes huge demands on everyone involved, including the prospective adoptive parents, the social workers and the children themselves. Pre-adoption placements can break down through no fault on anyone's part. Often, the children have been damaged by their experience before the adoption process begins. It is vital, therefore, that the prospective adoptive parents are given sufficient information about the children to enable them to make an informed choice, with the advice of social workers, about whether they are likely to be able to cope with the demands that pre-adoption placements will make upon them."

14. The Ombudsman also commented that it was vital that adequate and timely support should be provided for children and parents both during the pre-adoption placement and after the adoption.

Outcome

15. The Ombudsman noted that the council had already taken some positive actions, for example, through the provision of an enhanced adoption allowance and arrangements for counselling. But the Ombudsman concluded that in addition a substantial payment was required as a tangible mark of the council's recognition of the prolonged and profound distress its actions had caused Mr and Mrs Wright. Accordingly, the council was recommended to pay them £5,000.

(Report 97/A/3857)

K3: Child protection

Complaint about abuse of a child when in the council's care – compensation claim

1. Mr George alleged that a council did not adequately investigate his complaint that he was abused while in its care between the ages of three and 16. During that time he was placed in foster homes and children's homes. He said the council did not properly consider his complaint when he first complained in 1991, or when he asked for compensation in 1995, or when he complained again in 1998.

The complaint

2. Mr George said he was abused by a care worker. He felt that the council did not tell him properly, after his first complaint in 1991, whether his allegation had been upheld and, if it had been, what sort of compensation the council was prepared to offer him.

3. He complained again in 1995. The council asked the Criminal Injuries Compensation Board to consider awarding Mr George compensation. When this approach was not successful, the council did not pursue the complaint further.

4. Mr George obtained the help of an advocacy service in 1998 to pursue his complaint. The advocacy service was not satisfied with the way the council treated that complaint, and so complained to the Ombudsman on behalf of Mr George.

Investigation

5. The Ombudsman's investigation was concerned with the way in which the council dealt with Mr George's complaints and claims for compensation. The Ombudsman said that it was not the purpose of the investigation to establish whether Mr George was sexually abused and, if he had been, whether he should be compensated. That was a matter for Mr George's representatives to pursue with the council's insurers.

Faults

6. The Ombudsman identified the following faults by the council.

- The council held a meeting in 1991, involving the police and social workers, in order to identify necessary action; but the Ombudsman was not satisfied that all the action agreed at that meeting was taken.
- The council told Mr George in 1991 that it would ensure that the Department of Health was informed about his allegation, but it was not until some three years later that action was taken to have the alleged abuser's name added to the caution list for child care employment.
- The records of the investigation in 1991 were insufficient to enable the Ombudsman to conclude that the investigation was completed satisfactorily.
- The council did not explain to Mr George why it decided not to treat as a complaint the letter he sent to the user complaints officer in 1995.
- The council had still not decided Mr George's claim for compensation even though it had been outstanding for almost three years at the time of the Ombudsman's report.
- There was muddle, delay and poor communication in dealing with the complaint made on behalf of Mr George in 1998.

Injustice

7. The Ombudsman said Mr George was reasonably entitled to expect that the council would deal properly with his complaints. Its failure to do so caused him distress, frustration and time and trouble, which had been all the harder to bear because he suffered from mental ill health.

Outcome

8. The Ombudsman recommended that the council should set aside £1,000 for payment to Mr George. Because of Mr George's vulnerability, the Ombudsman recommended that the payment should be administered in Mr George's interest by his social worker.

9. The Ombudsman also recommended that the council should do all it reasonably could to ensure that its insurers dealt with Mr George's claim for compensation without any further delay.

(Report 98/A/3757)

K4: Child protection

Case conference – complaint by parent – errors – cumulative effect

1. Mr Ash complained that a council, after upholding several complaints from him in connection with a child protection case conference, wrongly considered each error in isolation when reaching its conclusion that these errors did not affect the outcome of the case conference. He said that, as a result, the council reached a wrong conclusion. He had not received proper acknowledgement that the decision of the case conference might have been different but for the council's failures.

Case conference

2. Mr Ash had two children, a daughter six years old and a teenage son. On one occasion, after the children had visited their maternal grandparents, the grandparents told the police and the council that Mr Ash's daughter had said and done things which suggested that she was being sexually abused by Mr Ash.

3. A child protection case conference decided to place the names of the two children on the child protection register. Their names were later removed.

4. Mr Ash made a complaint to the council about a number of matters, including the information presented to the case conference. His complaint was investigated at stage two of the social services complaints procedure. The investigating officer and the independent person upheld four parts of his complaint. They considered the effect of each of the errors separately and decided that in respect of each error the outcome of the conference was not affected. The investigating officer's report contained no comment or conclusion about the overall effect of the errors.

5. It was clear to the Ombudsman, and the council accepted, that the council did not consider the cumulative effect of the acknowledged mistakes. Furthermore, the Ombudsman concluded that the investigating officer's consideration of some of the mistakes individually was flawed. This was because the officer mistakenly believed that the case review sub-committee (which reviewed the decision of the conference because Mr and Mrs Ash disagreed with it) had considered the cumulative effect when it had not. Moreover, the investigating officer based one of her conclusions on a letter which the officer had clearly misunderstood and which itself was flawed.

The Ombudsman's view

6. The Ombudsman found that the failure to investigate properly the cumulative effect of the mistakes was maladministration. The Ombudsman said that the council should have considered whether, in the absence of those mistakes, the decision of the case conference would have been different.

7. The Ombudsman commented:

   "When investigating and responding to complaints it is not good enough simply to acknowledge that mistakes were made unless the complainant has stated in advance that such a declaration is all he or she seeks. If such mistakes are discovered, then the question of whether they had a material effect on the relevant outcome must be addressed in both the investigation and final response. If the conclusion is then reached that the mistakes had such a material effect to the detriment of the complainant, the question of an appropriate remedy must be addressed."

Injustice

8. The Ombudsman said Mr Ash was caused injustice because he had not had a proper investigation of, and response to, his complaint and he lost the possibility of an acknowledgement by the council that the decision of the case conference might have been different.

Outcome

9. The Ombudsman recommended that the council should:

- pay Mr Ash £150 for his time and trouble in pursuing his complaint and for the lost opportunity of a different outcome;
- place a copy of the Ombudsman's report with the relevant records; and
- provide training to its complaints investigators about the principles relevant to consideration of complaints as the Ombudsman described them (in paragraph 7 above) and how to put those principles into practice.

(Report 99/C/807)

K5: Child welfare

Communication – complaints procedure

1. Mr A complained that a council did not respond properly to information and enquiries from him about the welfare of his two daughters, Abby and Beth; it failed to inform him that Beth had become pregnant; and delayed unreasonably in dealing with his complaint.

Background

2. Mr A was not married to his daughters' mother. When their relationship broke down, she was given custody of Abby and Beth by a court. Around that time she married her new partner.

3. Over a number of years Mr A made various approaches to the council expressing concern about his daughters' welfare, alleging abuse by their mother and stepfather, neglect, and lack of suitable guidance about relationships.

4. Mr A made a complaint to the council which was investigated under the social services complaints procedure.

Communication

5. The Ombudsman saw no evidence of any adverse effect on the welfare of Mr A's daughters as a result of unreasonable failure by the council to take action. However, the Ombudsman was concerned about the council's numerous failures to reply to Mr A's communications and inform him of the outcome of relevant action which was taken. This was maladministration and, the Ombudsman said, a grossly insensitive way to treat a concerned parent.

6. This caused Mr A significant injustice, not only because the lack of information caused him more stress and worry than he need have suffered, but also because he lost all trust in the very agency he relied on to provide some protection for his daughters' welfare.

7. The Ombudsman did not uphold Mr A's complaint about the council not informing him that Beth was pregnant. The Ombudsman accepted that the council had good reason for not informing him. Mr A did not have parental responsibility and the council considered that, without the express permission of Beth or her mother, the council was not in a position to inform Mr A of Beth's pregnancy.

Complaint

8. The Ombudsman found that the council's social services complaints process had fallen into chaos. She identified 18 specific criticisms, including:

- failure to send Mr A details of the complaints procedure;
- excessive delay in appointing an investigation officer (the council's policy was that the investigation should be completed within 28 days but it took two months simply to appoint the investigating officer);
- failure of the investigating officer to make any attempt to deal quickly with the complaint, even though it had overrun the target completion time when the officer received it; and

- failure to meet the statutory duty to provide a response within 28 days (the council took over 10 months).

9. The Ombudsman commented:

"What strikes me most here is the overwhelming evidence of the lack of commitment by social work team managers to dealing with complaints. Clearly they are widely viewed as being a low priority burden. This, more than any other, is the main problem in this area that the council needs to address."

10. The Ombudsman was pleased to note that the council was taking steps to improve the way social services complaints were dealt with. The Ombudsman made some suggestions about features which could be considered, and these included demonstrating the council's commitment to achieving the relevant timescales by, for example:

- allocating complaints within three days of receipt;
- giving clear written instructions about the target date for completion;
- using only trained officers to investigate stage two complaints;
- establishing a small pool of independent stage two investigators to be available to be used in cases where no appropriate trained officer has the time to carry out a stage two investigation within the statutory timescale;
- providing officers appointed as stage two investigators with the guidance and time required to meet the statutory timescale;
- instituting an effective monitoring process; and
- making every effort to convince staff of the benefits of the new procedure and of the commitment of the council to it.

Remedy

11. The council agreed to pay Mr A £700 compensation in recognition of the injustice he suffered as a result of its failure to reply to his communications and the delay in dealing with his complaint.

(Report 99/C/1445)

K6: Placement

Teenager in care – proposed change of placement – complaints procedure – continuity in education

1. Ms X complained about the actions of a council on behalf of Ms Y. Ms Y was a teenager in the care of the council's social services department.

What happened

2. Ms X complained that the council failed to undertake stage two of its consideration of Ms Y's complaint within the 28 days required by law. In fact, four months had passed since the request that the complaint should go to stage two.

3. Ms Y had complained about the way in which social services staff responded to her views about her placement and the completion of her education to GCSE level.

4. Ms Y was placed in a children's home outside the council's area. She was attending a school at which she felt happy and where she wished to remain.

5. The council wanted Ms Y to transfer back to the council's area. Ms Y did not wish to return as she had been subjected to physical abuse by her brothers, who had traced her to a children's home in the council's area when she was placed there.

Outcome

6. The Ombudsman asked that stage two of the complaints procedure should be expedited; or alternatively that Ms Y be allowed to remain in her current home and school until the end of the academic year. That was Ms Y's preferred outcome.

7. The council agreed that Ms Y could remain in her current home and school until the end of the academic year. The Ombudsman accepted this was a reasonable outcome to the complaint.

(Local settlement 00/C/176)

K7: Services for adults

Vulnerable adult – allegations of abuse – change of residence – complaints procedure

1. Mrs Lamb complained that a council did not properly deal with the events leading up to and following the decision by her daughter Margaret to leave home. Margaret was a young adult with learning difficulties.

Particular concerns

2. In particular, Mrs Lamb complained that the council:

- failed to keep the family properly informed of Margaret's allegations of abuse and unhappiness at home;

- delayed in dealing with those allegations;
- dealt with Mrs Lamb and her family in a confrontational rather than a conciliatory or communicative way, by failing to arrange counselling and conciliation to resolve differences between the family and Margaret; and
- failed to investigate her formal complaint properly.

3. Mrs Lamb also complained that a social worker breached confidentiality by discussing with a prospective service provider a possible placement for Margaret. She felt this contributed significantly to the breakdown of relationships between Margaret and her family.

4. Mrs Lamb said that, by the time mediation was offered to the family, Margaret was already settled in an unsuitable placement away from home and was determined to remain there without contact with her family.

What the Ombudsman found

5. At the age of 19, Margaret left the residential school which she had attended since the age of nine and went to live with her mother and stepfather. The family and the council began consideration of what living arrangements might be best for Margaret. It was clear that there were significant differences between what the family considered would be best, what Margaret herself said she wanted, and what the council considered was an appropriate form of care and support.

6. A community care assessment was requested by Margaret's psychologist but no community care plan was completed. The Ombudsman commented that, if a plan had been prepared to include the views of both Margaret and her parents, there was a possibility that some reasonable compromise could have been achieved. If not, the council had an opportunity to make a clear statement that, where the views of the service user and the carers differed, it was Margaret's needs and views which had to be given priority.

7. The council did not offer counselling and conciliation to the family. The Ombudsman said that, if some form of formal conciliation had been attempted at an early stage, some resolution might have been achieved which would have allowed Margaret to leave home in a planned way.

8. The council became aware that Margaret was alleging that she was unhappy at home and that her stepfather hit her. The council had a clear written policy and procedure for dealing with allegations of the abuse of a vulnerable adult. That procedure required immediate action to be taken to determine the risk to the vulnerable adult and to assess the needs of both her and her carers. The council failed to take this action.

9. The council's failure to act in accordance with its own procedure, or with any sense of urgency, contributed to a crisis which led to Margaret leaving home in an unplanned and precipitous manner. Margaret chose to remain in unsuitable accommodation and in the care of someone who did not have the skills or experience to meet her needs properly and with whom her parents did not wish her to live.

10. The Ombudsman found there was clear evidence that Margaret's social worker breached confidentiality by discussing a possible placement prematurely with a prospective service provider. This was without the consent of the family and, in at least one instance, before discussing the matter with the family.

Complaints procedure

11. The Ombudsman found significant failings in the council's investigation into Mrs Lamb's complaint and in the report which arose out of the investigation. The independent investigating officer placed too much reliance on the council's version of events without making any attempt to obtain corroboration. The social worker's case history and version of events were presented as fact, relevant information was excluded, and information about the family's actions and attitude was not only incomplete and inaccurate but was presented in such a way as to show the family as unco-operative and obstructive.

12. The investigating officer suggested that the council's procedure on the mistreatment of adults should be reviewed. But in the report the officer did not include any detail of the procedure or specify in what way the procedure had been applied or misapplied in this case, or what part of the procedure required review. The investigating officer said these points were considered in depth in confidential appendices to her report which were sent to senior managers but not to Mr and Mrs Lamb. The Ombudsman said it was not appropriate for the council to conceal information considered as part of a complaint unless that information was genuinely confidential, which was not so in this case.

13. The council did not consider Mrs Lamb's complaint under the statutory social services complaints procedure because the council did not consider that she was a qualifying person. The council therefore considered the complaint under its non-statutory complaints procedure. But it failed to ensure, contrary to its own procedure, that someone independent of the social services department reviewed the complaint.

14. The Ombudsman found that the council's complaint investigation files were incomplete; that the external investigating officer failed to ensure that all relevant documents were returned to the council at the end of her involvement; the investigating officer was reluctant to comply with the Ombudsman's request for her interview notes, and those notes were incomplete. The Ombudsman observed:

    "The council's conduct of an investigation into a complaint should be transparent and open to scrutiny. The council is responsible for managing the complaints process even if an external person is commissioned to carry out the actual investigation."

Outcome

15. The Ombudsman recommended that, in recognition of the distress caused to her, the council should pay Mrs Lamb £500.

16. The council was also recommended to undertake a thorough review of its complaints procedure and instructions to investigating officers.

(Report 98/C/2)

K8: Social work support

Suspension of support – failure to act in an emergency – complaints procedure

1. Mrs Cork complained that a council failed to provide her with appropriate support for some two-and-a-half years; failed to respond appropriately when she was admitted to hospital; and failed to deliver a proper service for almost a year after that.

Family situation

2. Mrs Cork was a single parent living with her four children. The two youngest, Matthew and David, suffered from Attention Deficit Hyperactivity Disorder. Matthew also had a form of autism and learning difficulties. Both boys had severe behavioural difficulties which could only be partially controlled by drug therapy. Mrs Cork suffered from epileptic seizures brought on by stress.

3. The family had been known to the council's social services department for many years. The council arranged nursery care for David until he started primary school. Matthew was provided with a form of temporary fostering to give Mrs Cork some respite. That arrangement ended when there were problems finding a suitable placement. Despite requests from Mrs Cork she received no further support from social services for some two-and-a-half years. She collapsed as a result of stress and was admitted to hospital.

Emergency

4. Medical staff contacted the council to ask that the family should be visited, as Matthew and David and their older brother were being cared for by their sister Debbie. Debbie was 16 at the time.

5. Instead of visiting to assess the situation, a council officer telephoned and decided, after speaking to Debbie, that she could manage. Amongst the responsibilities Debbie was assuming was the administration of medication to Matthew and David. No visit was made to the family home for four days.

6. Two months later the council offered some help to Mrs Cork which she thought was unsuitable for the boys' needs. No other provision was made and the council failed to review the case after six months, as required by its own procedures.

Complaint

7. Mrs Cork made a formal complaint to the council. This led to consideration at the final stage by a review panel.

8. The review panel upheld Mrs Cork's complaints and commented that the social services' record in relation to the family had to rank as one of the worst on record.

9. The panel considered that the service to the family had been nonexistent for the two-and-a-half years before Mrs Cork was admitted to hospital. After that, apart from the allocation of a social worker, the panel could find no evidence of any significant change in the family's situation.

10. The review panel made 16 recommendations to the council. The council accepted them and apologised.

Complaint to the Ombudsman

11. Mrs Cork then complained to the Ombudsman because she did not

believe that apologies were a sufficient remedy, and because she hoped that steps could be taken to ensure that the same did not happen to someone else.

12. The council then considered the question of compensation and decided to offer £12,000 to the family.

13. The Ombudsman concluded that the review panel's concern was justified and that the forceful language it used to describe the shortcomings of the council's performance was not exaggerated.

14. The Ombudsman also concluded the council's poor handling of the matter had been compounded by the fact that Mrs Cork had to exhaust the council's complaints procedure and then complain to the Ombudsman before obtaining a full remedy for the mistreatment of her family.

15. The Ombudsman accepted that the compensation proposed by the council was reasonable.

(Report 00/C/575)