



Section L

# Social services

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# L1: Aftercare services

## Discharge from hospital after compulsory detention – aftercare – failure to follow policy – whether charging lawful – deferred settlement of complaint

Ms A complained on behalf of her mother, Mrs A, that a council wrongly charged her for residential care costs. Ms A said that, as a result, it was necessary to sell Mrs A's property in order to meet the costs of her care.

mother's residential care. She was not satisfied with the council's response and complained to the Ombudsman.

### What happened

1. Mrs A suffered from long-term mental health problems. In May 1995 she was detained in hospital under section 3 of the Mental Health Act 1983. After her discharge, she moved to a residential home, with aftercare arranged by the council under section 117 of the 1983 Act.
2. The residential placement was arranged by Mrs A's family and was paid for by her.
3. There was Government advice at the time that services provided under section 117 could not be subject to charging. Ms A said that, at the time, she was not aware of this.
4. Later, in September 1999, after Mrs A had another spell in hospital, she moved to another residential home and the council met the full cost of her placement there.
5. At that time there was national debate about the question of councils charging for services provided as aftercare under section 117. The issue was considered by the High Court in a case involving four separate local authorities. The Court confirmed that charges could not be made for aftercare services, including accommodation, provided under section 117. That decision was upheld by the Court of Appeal.
6. Ms A became aware of the debate about section 117 aftercare. She raised the matter with the council and asked why the family, rather than the council, had always arranged and paid for her

### Outcome

7. The Ombudsman noted that it was the council's policy at the relevant time not to charge for aftercare provision. The council accepted that its responsibility for meeting Mrs A's needs had not been adequately considered.
8. The council agreed in principle to reimburse the cost the family had incurred for the period of almost four years until September 1999 when it had taken over the funding. At this time the court decision was under appeal to the House of Lords. It was therefore agreed between the council and the Ombudsman that there would be a settlement of the complaint in two stages:
  - that first the council would make a payment of £500; and
  - that, when the decision of the House of Lords about section 117 funding was known, the question of a further payment would be considered on the basis that, if the House of Lords said that payments by councils were lawful, the council would reimburse the costs of the family for the period of almost four years to September 1999, together with interest at the County Court rate.
9. Following the decision of the House of Lords later that it was lawful for councils to pay for section 117 aftercare, the council reimbursed the sums paid together with interest. This came to a total of some £88,000.

*(Local settlement 99/B/1670)*

## L2: Care services

### Failure to implement recommendation from assessment – failure to consider alternative provision – failure to monitor provision

Mrs Ford complained that a council failed to make adequate provision for her son Alan's needs after he left school.

#### Needs and provision

1. Alan was blind and had a hearing impairment which affected his speech. He had problems with balance which affected his mobility. After leaving school he attended a local multi-purpose day centre for five days a week.
2. In 1994 Alan's social worker carried out an assessment of his needs. The assessment report recommended a significant level of one-to-one support.
3. The Ombudsman found that the council failed by a wide margin to implement the 1994 assessment. Initially there was only two hours per week one-to-one support, later increased to six hours. But only shortly after that the council accepted a report by a charity which recommended full-time one-to-one support.
4. The Ombudsman thought that the council failed to acknowledge the full extent of Alan's needs, and failed to provide the one-to-one support the 1994 assessment showed he required. Those failures were maladministration.
5. The Ombudsman was concerned about the way in which the provision was monitored. There were deficiencies in the care plan which were not identified by those responsible for implementing it. That failure, too, was maladministration.

6. It appeared there was general agreement that the day centre was not entirely appropriate to Alan's needs. But no investigation was carried out into possible alternatives for some years. The failure to address that issue adequately was also maladministration.
7. The council was also at fault, the Ombudsman said, for not properly considering how to meet Mrs Ford's needs as a carer.

#### Outcome

8. At the time of his report the Ombudsman was pleased to note that Alan then had a care plan in which Mrs Ford had a greater degree of confidence. That provided a partial remedy for her complaint.
9. But the Ombudsman believed that Alan would have benefited from dedicated individual provision at an earlier stage. That was not delivered properly, over a period of some four years, and that was a substantial injustice.
10. The Ombudsman recommended that the council should:
  - pay compensation of £6,000 to Alan and Mrs Ford; and
  - review its arrangements for people with multiple sensory disabilities.

*(Report 00/B/9315)*

## L3: Care services

### Assessment – prioritising work – complaints procedure

Mrs Rose complained that a council failed to assess the needs of her son and failed to make proper arrangements to meet his needs and the needs of the family as his carers.

Mr and Mrs Rose unable to plan for their son's care.

#### The circumstances

1. Mrs Rose's son, when a young teenager, had bone cancer. He had one leg amputated. Mrs Rose was concerned about assistance for him and the family when he returned home from hospital.
2. There was a long wait, of some 18 months, before her son was allocated an occupational therapist to carry out an assessment.
3. The council said it had an agreed practice with the Health Service about when referrals would be taken. But the Ombudsman found that this was not included in any written procedure or guidance, and there was confusion about the point at which a referral should be made. The Ombudsman said that the council should ensure that a referral system was established and set out in writing, so that officers and users were aware of what should happen and when.
4. The Ombudsman also found that the council's system for prioritising work was ineffective. The result was that the majority of referrals, which would include a range of people with different needs and different levels of urgency, were placed in the same priority group.
5. The Ombudsman said that the council was failing in its duties to those in need in its area. The council needed to address that problem as a matter of urgency. The delay in assessment left

#### Complaint

6. The Ombudsman found that no-one within the council ensured that Mr and Mrs Rose received an adequate response to their complaint and an explanation of what they could do if they remained dissatisfied.
7. There was a failure to follow the statutory complaints procedure. The complaint should have been treated as a formal complaint under the statutory procedure, and registered and dealt with as such. Mr and Mrs Rose completed a corporate complaints form, but the Ombudsman said they could not be expected to know the differences between the two procedures, and there seemed to be some confusion on the point among the council's own staff.
8. Mr and Mrs Rose received no adequate response to their complaint.

#### Housing

9. The council knew that Mr and Mrs Rose were having some difficulty in deciding whether they needed rehousing or whether their existing home might be adapted. They were offered two properties, neither of which they felt able to assess for themselves. The council was provided with a brief report from the hospital occupational therapist on the first property, but the second was not seen by an occupational therapist. This was a consequence of the failure to provide an assessment within a reasonable time.

### Review

10. The council accepted that the delay between referral and allocation for assessment was unacceptable, and determined to take action to address the problem. The Ombudsman said it was urgent to introduce some means for differentiating between referrals needing greater and lesser priority. The current system was not working.

11. The council agreed that it would seek to ensure that its complaints systems, both corporate and social services, were satisfactory.

### Outcome

12. The council agreed to make a payment of £750 compensation.

*(Report 01/C/9625)*

## L4: Care services

### Lack of provision – fettering of discretion

Mr Bird complained that his mother did not receive the home care for which she was assessed after leaving residential nursing care.

#### Lack of provision

1. The council was unable to provide, through its approved contractors, the two evening carers Mr Bird's mother needed. The council's policy did not allow for purchase of care from any provider other than the approved contractors for the area. The council did not maintain any reserve list of contractors from whom care could be purchased if none of the approved ones could provide a service.

#### The Ombudsman's view

2. The Ombudsman applauded the council's intention to provide a quality assured and easily controllable service. But, in making those plans, the council provided inadequately for the needs of those few individuals who could not be catered for within the standard arrangements.

3. The Ombudsman commented:

*"In the final analysis it must be the needs of individuals which determine the council's response and not the requirements of its contractual arrangements, no matter how generally sensible they may be. In allowing no mechanism by which managers could step outside the general policy in respect of the use of approved carers, the council fettered its own discretion. That was maladministration."*

#### Outcome

4. The council reviewed its policy. It built in the flexibility required to cope with service users whose care needs might not be met if the approved list system were operated rigidly.
5. The council agreed to reimburse Mr Bird for the private care he purchased, and to pay him £500 for his time, trouble and distress.

*(Report 01/B/305)*

# L5: Care services

## Assessment – care plan – rehousing – conduct of client

Mr Ryan complained that a council did not provide proper services to his wife, himself and their severely disabled daughter.

### The family circumstances

1. Mr and Mrs Ryan lived in a single-storey two bedroom cottage with their teenage son and their daughter, Mary. Mary had global disabilities and was dependent on the care of others for all her needs. She was aged nine at the time of the events complained of.
2. After Mrs Ryan was involved in a car accident, Mr Ryan gave up his job and became Mary's main carer.
3. Mr Ryan complained about the provision of care services, assessment of Mary's care needs and those of her family, and the provision of adequate housing.

### Social services

4. The Ombudsman found that there was a catalogue of failures:
  - a delay of five months before the council began an assessment of Mary's care needs;
  - withdrawal of home support although this provision was included in the care plan;
  - a delay of six months in responding to a request for reassessment of needs;
  - a delay of 10 months in responding to a request for an assessment of Mr and Mrs Ryan's health needs; and
  - failure to seek a medical opinion to help establish the level of service needed for inclusion in Mary's care plan.

### Rehousing

5. The Ombudsman also found faults in the way Mr Ryan's request for rehousing was handled:
  - delay by the social services department in referring the request to the housing department;
  - not all officers who needed to see the housing needs report did so;
  - treating the application as a general one to which the policy on owner occupiers applied, rather than one of special need; and
  - failure to consider the exercise of discretion to rehouse outside policy.
6. The Ombudsman commented:

*"Many of the problems encountered by the application could have been addressed if the officers involved had all met to discuss it."*

7. The Ombudsman also said that the complaint about failure to rehouse the family should have been dealt with under the social services statutory complaints procedure, as the application arose out of a stated need in a care plan.

### Conduct of the client

8. The Ombudsman noted that many officers, though not all, said that the attitude of Mr Ryan prevented the council from providing all the services to Mary that it otherwise would have done. The Ombudsman therefore considered whether Mr Ryan's conduct in any way mitigated the failures by the council. The Ombudsman commented:

*“It is clear that some officers were intimidated by Mr Ryan and that on occasions he expressed himself in a way which officers found intimidating and offensive. However, it must be said that Mr Ryan was a man under extreme pressure, which was recognised in reports prepared by the council, and that the earlier service his daughter had received from the council was poor. Whilst in no way condoning the way Mr Ryan sometimes expressed himself, I consider that his frustration was understandable and that at times his indignation and anger were almost inevitable. I have no desire to be critical of officers who do a difficult job and should be able to do this job without fear of physical assault or personal insult. However, I have seen no evidence that Mr Ryan’s behaviour was so extreme or so unfounded that it would prevent officers from being able to provide*

*a proper service to his daughter or the rest of his family, nor should it have done.”*

### Outcome

9. The council offered to pay Mr Ryan £4,000 in recognition of failures in its services. The Ombudsman considered that a satisfactory remedy, and commended the council for its positive response. The council also reviewed its arrangements in a number of respects, including the drafting of a policy to assist officers dealing with complainants who presented challenging behaviour.

*(Report 00/C/12118 et al)*

# L6: Child protection

## Delays – failure to follow guidance – statutory complaints procedure – access to records

Mr A, his daughter Ms A and her husband Mr B complained about the way a council dealt with child protection issues concerning Ms A's and Mr B's four children.

### Procedures

1. The Ombudsman accepted that councils were obliged to act where they reasonably suspected that a child could be at risk. In this case, the Ombudsman said the council was acting reasonably in deciding to carry out an investigation following allegations made against Mr A.
2. However, the Ombudsman pointed out a number of failings:
  - the council took much longer to call a strategy meeting and interview the children than Government guidelines envisaged and, if the children had been at risk, that delay could have been crucial;
  - the guidelines expected the council to involve the parents where possible and treat them with sympathy, but this was not done;
  - there was a delay in convening a child protection conference;
  - the social worker's report to the child protection conference was inadequate; and
  - the record of the conference included a recommendation which was not referred to at the time.

### Statutory complaints procedure

3. Mr A made a complaint under the statutory complaints procedure. The

Ombudsman criticised the way the council dealt with this because:

- the designated complaints officer assumed that Mr A did not wish to pursue his complaint after the first stage, but it was clear that Mr A was never offered the opportunity in writing to move to the next stage;
- Mr A then had to go through the council's corporate procedure which was not designed to deal with such complaints; and
- it was not clear whether the report then issued by the investigating officer was a final version.

### Access to records

4. The complainants requested access to all files which contained information about them and the children. The Ombudsman said that this request was handled in a particularly ineffective way by the council.
5. The law allowed a period of 40 days for access to files to take place. The Ombudsman found that the council took more than six months to provide access.

### Outcome

6. The council carried out a review of its procedures, and agreed to pay £1,000 to the complainants.

*(Report 01/B/16046)*

## L7: Child protection

Separated parents – concerns expressed by father and by school – failure to investigate or allocate social worker – significant neglect of children

A Member of Parliament complained on behalf of Mr Barker that a council failed to take adequate action to safeguard the wellbeing of his children.

### What happened

1. Mr Barker and his partner separated. Their three children, then aged seven, five and two, stayed with their mother. Mr Barker soon became concerned about the way the children were being treated and made a number of complaints to the social services department over a two-year period. These included allegations that the children were left on their own at night, that they were going hungry, were dirty, and were not getting enough sleep. Mr Barker also said he believed that drug use was going on in the house and that his children were witnessing this.
2. At this time concerns were also being raised with the council by the children's school. The headteacher expressed concerns about the son's behaviour, and regularly raised concerns that the children were tired and withdrawn and that they sometimes had minor bruises and burns.
3. A social worker visited and noted that the children said they had been hit by their mother's boyfriend, were left on their own and had seen drugs used in the house. Despite this it was recorded that there was no evidence to support the allegations that had been made by the school.
4. The council did not allocate a social worker to the family. Mr Barker's concerns were considered by the social work team as being motivated by the acrimonious nature of the break-up of his relationship.

5. After some two years, Mr Barker began an application for a residence and parental responsibility order. At that point a social worker was assigned to work with the family. The five-year-old daughter disclosed that she had been sexually abused. The children were all removed from their mother and placed with foster carers.
6. Mr Barker told the Ombudsman he had spent two years trying to convince the social services department that his children were at serious risk, only to find that his concerns were not addressed and his motives questioned. As a consequence, his children were unnecessarily left at risk for an unacceptable length of time. Their welfare and safety were not treated as of paramount importance, and they suffered neglect and abuse as a direct result of the council's inaction.

### The Ombudsman's view

7. The Ombudsman commented:

*"I have found this a profoundly disturbing case. The persistent failure by the social services duty team to investigate the numerous allegations that were made had grave consequences for the children concerned, which could easily have been much worse."*

8. The Ombudsman said that the attitude of staff towards Mr Barker was inexcusable and exacerbated the distress that he was experiencing.
9. The Ombudsman found that the concerns expressed by both Mr Barker and his children's school were largely ignored. No proper investigation was carried out, nor was any social worker assigned to the family. Those failures

were maladministration. All three children experienced significant neglect. It was reasonable to assume that some of that ill-treatment could have been avoided.

### Outcome

10. The council agreed to pay £2,000 to Mr Barker; £5,000 each to two of the children and £2,500 to the other child, to be held in trust until they were 18.

11. The Ombudsman observed that no amount of money could remedy the damage resulting from the neglect, but that the sums were sufficient to recognise the injustice from the council's maladministration in not acting sooner to remove the children.

*(Report 00/C/16780)*

## L8: Child protection

### Abuse by parent – threats against informant – delay by council in providing help – complaints procedure

Ms Lane complained about the actions of a council in respect of a child protection investigation.

#### What happened

1. Ms Lane learned that her 15-year-old half sister was pregnant by their father. She was concerned and told her own social worker and the social services department in the area where her sister lived. She told that department that her father had threatened to harm her if she told the council that he had abused his children.
2. The council began a child protection investigation. Ms Lane complained that the council:
  - did not inform her before it disclosed her identity as an informant in child protection court proceedings;
  - failed to offer her practical support, including support for rehousing following threats of violence from her family;
  - delayed in its investigation of her complaints; and
  - failed to provide an adequate remedy to her complaints.

#### Disclosure

3. The Ombudsman accepted that the council could divulge the names of informants in child protection cases. The council's records showed that Ms Lane repeatedly raised concerns that her family would harm her if they knew she had provided information to the authorities in connection with the child protection investigation and the care

proceedings relating to her young half sisters and the child of the older sister. The records also showed that the council intended to forewarn Ms Lane that it was going to disclose her identity in papers submitted to the court. But the intended meeting did not take place, and Ms Lane only learned of the council's decision after members of her extended family had seen her identified in the court papers.

4. The Ombudsman considered that the officers were at fault in not discussing the matter with Ms Lane before submitting the statement to the court. They paid inadequate regard to the likely impact of this on Ms Lane and her children.

#### Practical help

5. The Ombudsman also found that the council delayed significantly in helping Ms Lane to move. In the end, the council did write a letter of support to her landlord and that had some influence in that the landlord assisted Ms Lane with a move.

#### Complaint investigation

6. The Ombudsman criticised the council's handling of Ms Lane's complaint. It took five months longer than the time set in the statutory complaints procedure. It also delayed unreasonably in providing the director of social services' response to the recommendations of the review panel.
7. The Ombudsman said that much of the delay should have been avoided, given Ms Lane's vulnerable position and the risks she had taken to provide information to the council.

8. The Ombudsman noted that the review panel had recommended that the director of social services should take steps to ensure that, in future, members of the public providing information to the council in connection with child protection enquiries were given clear and unambiguous information, preferably in writing, about the different investigations which might take place and how they might affect confidentiality. The council had not yet taken those steps.

#### Outcome

9. The Ombudsman recommended that the council should pay compensation of £1,500 to Ms Lane, complete its review of child protection procedures and draw up information for members of the public as recommended by the review panel.

*(Report not for publication – 99/A/2331)*

# L9: Child welfare

## Complaint upheld by council – no remedy provided – approach to compensation limited to legal liability

Mr Field complained about a council's response to his request for support following an accident.

### Circumstances

1. Mr Field was a single parent with two young children. He suffered an accident which left him immobile and unable to provide practical care to his children. His complaint was that the council did not give him or his children proper support, help or advice.

### Complaint to the council

2. Mr Field made a complaint to the council. The investigating officer upheld his complaint. But the council did not provide him with a remedy.
3. The reason for this was that the council's practice was to consider only whether the council was legally liable. If it was not, the council did not pay compensation.

### Approach to remedy

4. The Ombudsman said that she would not have expected the council to restrict itself to identifying its legal liability before paying compensation. Mr Field received no tangible remedy for what he and his family suffered. That cast doubt on the effectiveness of the council's complaints procedure.

### Outcome

5. The council said that it would adopt a different approach to compensation in future and would not restrict itself only to paying compensation in circumstances where it believed it had a legal liability.
6. The council also agreed to:
  - offer to do an assessment of all the needs of Mr Field and his children, draw up appropriate care plans, and see to the provision of any services identified by the assessments; and
  - pay Mr Field £1,500 compensation.

*(Report 01/C/5968)*

# L10: Fostering

## Preparation – social worker support – complaint investigation – role of review panel

Mr and Mrs Fleming complained about the actions of a council in relation to their role as foster parents.

The social worker's case records and diary were subsequently falsified to make it appear that support had been provided earlier than it actually had been.

### Complaint

1. In particular Mr and Mrs Fleming complained that:
  - the council did not give them sufficient preparation for becoming foster parents, or adequate information about the payment scheme;
  - they were given insufficient social worker support during the placement with them of two children; and
  - they considered the review panel that adjudicated on their formal complaint to be oppressive, biased and discriminatory.

### Preparation

2. The Ombudsman's investigation established that Mr and Mrs Fleming were given insufficient information before changing their role from foster parents under the council's shared care scheme to mainstream fostering.
3. The council had already apologised for failures in its communication with Mr and Mrs Fleming. The Ombudsman considered that a satisfactory remedy for the first part of the complaint.

### Social worker support

4. The Ombudsman found that social worker support was insufficient during a period when the placement of the two children was in crisis. Telephone calls and a letter from Mr and Mrs Fleming asking for help were not responded to.

### Complaint investigation

5. Mrs and Mrs Fleming made a formal complaint to the council. The investigation by the council's investigating officer was flawed because:
  - he did not examine the case records on the children and the diary record kept by Mr and Mrs Fleming during the placement;
  - he concluded that support had been sufficient despite there having been no response to the telephone calls and a letter asking for help; and
  - he failed entirely to address the issue of the discrepancies between what Mr and Mrs Fleming were saying about the visits of social work staff and what their social worker was saying.

### Review panel

6. The review panel did not uphold any of Mr and Mrs Fleming's complaints, even the complaint which the council had already admitted was justified and had made an apology for.
7. The Ombudsman did not uphold the complaint that the review panel had been oppressive and discriminatory in its approach. However, the Ombudsman was concerned that:
  - the chair of the review panel did not know he had the power to reject a

council investigation report and require a fresh investigation;

- the panel did not notice the flaws in the investigation process even though some of them (for example the automatic acceptance of uncorroborated evidence of council officers) should have been obvious;
  - the panel was aware of unresolved conflicts of evidence but, notwithstanding that, decided not to uphold any of the complaints;
  - the chair did not know he could ask for additional investigation of specific matters, but thought he had to determine complaints on the basis of whatever evidence the council chose to place before the panel; and
  - the panel decided that Mr and Mrs Fleming's letter requesting assistance did not warrant an urgent response (the Ombudsman found that all the professional staff who were questioned about it said that it did).
8. The Ombudsman found that the council was at fault for not providing the chair and other panel members with proper support, guidance and training to enable them to carry out their responsibilities properly. The failure of the review panel to consider and determine Mr and Mrs Fleming's complaint in a thorough and fair way was maladministration.
9. The council's arrangements required that the composition of panels should reflect the gender and ethnicity of complainants. It appeared that no attempt was made to follow that guidance in this case.

## Outcome

10. The council agreed to:

- arrange a meeting between Mr and Mrs Fleming and the director of social services so that he could apologise personally to them for the mistakes his department made;
- provide Mr and Mrs Fleming, on request, with a testimonial letter setting out the excellence of the care they provided as foster parents;
- pay them £1,000 compensation;
- provide training in complaints investigation to officers of the council who were required to undertake that work;
- review the guidance concerning the holding of review panels and ensure that, in future, the guidance about gender and ethnicity was followed;
- provide training to ensure that members of review panels fully understood the extent of their responsibilities under the legislation; and
- identify and correct errors in the case files of the two children.

*(Report 01/C/9018)*

# L11: Residential care

## Assessment – power of attorney

Mr and Mrs Bridle complained that a council did not deal properly with arrangements for the care needs of Mrs Bridle's mother, Mrs Sedge, on her discharge from hospital.

### Assessment

1. The complaint mostly concerned the assessment of Mrs Sedge's care needs. The Ombudsman found a number of failures by the council since it:
  - did not notify Mr and Mrs Bridle about the assessment of the care needs of Mrs Sedge or involve them in it, and did not provide them with a copy of the service plan which resulted;
  - produced an assessment which contained inconsistent information and an incorrect conclusion about the type of care required by Mrs Sedge;
  - took action about Mrs Sedge's care which was inconsistent with, and failed to have regard to, the status of Mr and Mrs Bridle as holders of enduring power of attorney over Mrs Sedge's affairs;
  - unreasonably failed to provide Mr and Mrs Bridle with written information about residential and nursing home care and its funding when they asked for it;
  - wrongly completed a financial assessment form to show that Mrs Sedge needed nursing care, whereas all she required was residential care, and wrongly told Mr and Mrs Bridle that there were no financial implications as the costs of residential care and nursing care were the same;
  - failed to notify Mr and Mrs Bridle of a review of Mrs Sedge's situation; and

- made an incorrect statement about the unavailability of Mr and Mrs Bridle on a form connected with the review, when they had not been informed that the review was to take place.

### Complaint

2. Following local government reorganisation, the successor council failed to deal adequately with a complaint from Mr and Mrs Bridle. The council's delay in dealing with the complaint and its response to the complaint led Mr and Mrs Bridle to instruct lawyers.

### Outcome

3. The Ombudsman said that there was no doubt that the council's maladministration in its handling of Mrs Sedge's assessment and its dealings with Mr and Mrs Bridle led to a great deal of unnecessary expense, time and trouble for them.
4. The Ombudsman recommended that the council should pay Mr and Mrs Bridle some £6,900 to cover the unnecessary excess payments made for nursing care and consequent loss of attendance allowance. The Ombudsman also recognised that, as a professional person being granted enduring power of attorney, Mr Bridle was entitled to be paid at his professional rate. The Ombudsman accepted that the work which he detailed was caused through the maladministration of the two councils and he should be reimbursed.
5. The total recommended payment was £23,542, plus reasonable legal costs.

*(Report 00/C/3176)*