LONDON BOROUGH OF CROYDON

REPORT:	**CABINET** **22 March 2023**	
REPORT TITLE:	**Local Government & Social Care Ombudsman Report Finding of Fault causing Injustice and Report by the Monitoring Officer under section 5A of the Local Government and Housing Act 1989**	
CORPORATE DIRECTOR / DIRECTOR:	**Annette McPartland, Corporate Director of Adult Services,** **Debbie Jones, Corporate Director Children, Young People & Education** **Stephen Lawrence-Orumwence Director of Legal Services and Monitoring Officer** **Roisin Madden, Director, Children's Social Care, and** **Simon Robson, Director, Adults Services.**	
LEAD OFFICER:	**Roisin Madden, Director, Children's Social Care, and** **Simon Robson, Director, Adults Services.**	
LEAD MEMBER:	**Councillor Yvette Hopley** **Councillor Maria Gatland**	
KEY DECISION? [Insert Ref. Number if a Key Decision] ***Guidance**: A Key Decision reference number will be allocated upon submission of a forward plan entry to Democratic Services.*	**No**	
CONTAINS EXEMPT INFORMATION? ***(* See guidance)***	**No**	
WARDS AFFECTED:	N/A	

1. SUMMARY OF REPORT

1.1 A complainant who we refer to as Ms B, complained that after October 2019 the Council did not support her in arranging suitable respite care for her disabled son, Mr C. Ms B made separate complaints to Children's and Adult Services as her complaint spanned the time when Mr C moved between the two services. On 14th July 2022 the LGSCO wrote to the Chief Executive Katherine Kerswell to confirm that after consideration of a complaint they had received, they decided to issue their findings as a public interest report.

1.2 The LGSCO consider six criteria when deciding whether to issue a public interest report, these are:

- Recurrent faults (for example, the organisation keeps making similar mistakes)
- Significant fault, injustice, or remedy (by scale or the number of people affected)
- Non-compliance with an Ombudsman's recommendation (the organisation has not agreed or has not carried out the recommendations of the LGSCO)
- A high volume of complaints on a subject
- A significant topical issue
- Systemic problems and/or wider lessons (for example, problems with how the organisation does things that if not put right are likely to affect others, and this is an opportunity for others to learn).

1.3 In this case the reasons for issuing the report are:

- Significant Fault, Injustice or Remedy
- Systemic problems and/or wider lessons
- This report also contains the statutory report of the Council's Monitoring Officer which was triggered as a result of the contents of the LGSCO report and outlines the Council's statutory response required.

To remedy the injustice caused, the Ombudsman has made the following recommendations.

1.4 Provide Ms B with an unqualified apology from a senior officer (Director level or above) recognising the injustice she has been caused.

1.5 Pay Ms B £3,000 to recognise the loss of service experienced by her and Mr C outlined above; pay Ms B £500 to recognise her distress and an additional £500 to recognise her time and trouble – making £4,000 in total.

1.6 Agree that for so long as it is needed the Council will provide Ms B with direct payments to fund respite care for Mr C, from his existing respite provider, at the same level he received before October 2019. It can withdraw this support once Mr C moves to another placement where such respite is no longer needed (we note Mr C is due to move to a supported living placement soon).

1.7 Carry out more work to understand why, when Mr C was a client of its Children's Services, the Council did not do more to search for, or record, how his respite care needs could be met between December 2019 and December 2020. The Council should undertake research to establish if this was a one-off service failure or symptomatic of any wider failings in its Children's Services in identifying suitable respite placements. If it is the latter, then the Council should produce an action plan setting out measures designed to prevent a repeat which can include reference to the new framework with respite care providers it referred to in response to our draft report.

1.8 Give a commitment that it will end its practice of delaying the registration of stage two complaints made under the statutory complaint process for children's complaints to await clarification or meetings.

1.9 Brief all staff in its Transitions Service to make it clear the Council should not seek to refuse or limit care choices on basis of cost, or through comparison with national or local averages. All staff must be reminded that decisions on the care individual clients receive must be based on their assessment of need and must be sufficient to meet those needs.

2. RECOMMENDATIONS

The Executive Mayor in Cabinet is asked to:

2.1 Consider the public interest report dated 28 November 2022 and the recommendations made by the Local Government & Social Care Ombudsman (LGSCO) in relation to Croydon Council set out in Appendix 1.

2.2 Accept the findings and agree the recommendations set out in the public interest report.

2.3 Endorse the actions taken by the Council and note the steps, progress, and timeline to implement the recommendations set out in section 6 of this report.

2.4 Adopt the report as the Council's formal response under section 31 of the Local Government Act 1974 to be communicated to the Ombudsman.

2.5 Adopt the report as the Executive's formal response as required by section 5A of the Local Government and Housing Act 1989 for distribution to all members and the Monitoring Officer.

3. REASONS FOR RECOMMENDATIONS

3.1 The complainant who we refer to as Ms B complained that after October 2019 the Council did not support her in arranging suitable respite care for her disabled son, Mr C. Ms B made separate complaints to Children's and Adult Services as her complaint spanned the time when Mr C moved between the two services.

The Ombudsman's findings found failings including:

- Failing to adequately seek alternative respite for Mr C
- Delaying in the completion of the Complaints Process
- Lack of emergency care planning for Mr C to run alongside the need for emergency planning for his education
- The Council failed to conduct additional suitability checks on subsequent providers following the failure of the first care provider to meet the needs of Mr C
- The Council took a budget led approach to the respite needs of Mr C and not a needs led approach
- Failure to undertake a Carer's Assessment that would be compliant with the requirements of the Care Act 2014 and provide Ms B with her own support plan

- Failure to conduct a proper assessment of Mr C's overnight respite needs

- Failure to set a realistic personal budget for Mr C's care

3.2 The Ombudsman concluded that the failing identified had led to Ms B and Mr C experiencing the following injustice:

- They suffered a prolonged and significant loss of service by having no respite care between December 2019 and August 2021 (20 months).

- They suffered a further loss of service by having inadequate respite care and insufficient funds to purchase other care Mr C needed after September 2021.

- They suffered a further loss of service when the Council withdrew funding to support Mr C's placement at School X and failed to respond to the additional burden of care that would fall on Ms B as a result.

- Ms B was caused significant unnecessary distress by the Council's approach to her Son's care. She has explained in her own words, the impact of the Council's actions upon her.

- Ms B was put to significant unnecessary time, trouble, and frustration by the Council's Children's Services complaint handling and in her contacts with its Transitions Service when she consistently explained the position the Council's actions had put her in.

4. BACKGROUND AND DETAILS

What follows is a brief chronology of the complaint.

4.1 Ms B complained to the council in December 2020 due to over 12 months had passed since Mr C last received respite care. The Council replied later that month, under Stage One of the Children's Complaint Procedure. The Council acknowledged and apologised for Mr C's lack of overnight respite.

4.2 Ms B escalated her complaint to a Stage 2 in January 2021. There were delays in the progression of this investigation, and in the interim Mr C's school place was also ended due to a negative Ofsted rating of his school provision.

4.3 Mr C's provision of services transferred to Transition /Adults Social Care and Ms B complained about the personal budget set as a result of Care Act assessment and a formal Stage 2 complaint investigation was only recorded and started in June 2021.

4.4 In July 2021 a further complaint was registered in relation to provision of services for Mr C. Ms B complained about the continuing lack of respite care and that the Council would not pay for respite.

4.5 Between July and December 2021, a number of negotiations and options were explored between the Council and Ms B to support Mr C's needs.

4.6 In December 2021 the Council's own Stage 2 complaint's process was completed and most of Ms B's complaints were upheld. An apology was offered.

4.7 In January 2022, Mr C's care package was increased.

4.8 Ms B approached the Ombudsman as she remained unhappy with the services provided by the council to Mr C.

4.9 Details of the full scope and investigation of the complaint can be found in the Ombudsman report in Appendix 1.

What follows is a summary of the Ombudsman conclusions from the Final Decision report:

4.10 That Mr C's (a child at the time) Mother, Ms B having cause to raise concerns that respite care stopped in October 2019 and the Council became aware of this no later than December 2019. The investigation recognised the difficulties the Council had in arranging care both respite care and more generally once the COVID-19 pandemic began in March 2020. But found this offered little in the way of mitigation for the Council. Its efforts were clearly inadequate in securing alternative overnight respite. That was fault, as the Council has already accepted. We recognise also that it has apologised for this.

4.11 That complaint process then took a further 12 months to complete. This meant by the time the investigation outcomes were reported and responded to by the Council, Mr C's case was already being managed by its Transitions Service, part of Adult Social Care services. We consider fault by the Council contributed to this delay.

4.12 During the time Ms B's complaint to Children's Services was under investigation her need for respite care became even more acute. Because in March 2021 the Council decided it would no longer fund Mr C's placement at School X. We have not seen any evidence of emergency care planning for Mr C to run alongside the need for emergency planning for his education. That was fault.

4.13 We recognise that once Mr C's case transferred to the Transitions team it made some new effort to find respite care for Mr C. We do not consider any fault attaches to the Council for the failure of the provider, CP1, to meet his needs during the respite trial in April. But the Council did not heed the lessons of that failure. If a care provider which claimed to be experienced in meeting the needs of young adults like Mr C could not meet his needs, then this should have led the Council to make extra checks of providers to ensure they were suitable.

4.14 Ombudsman also notes a "fundamental flaw in the Council's approach to meeting Mr C's need for respite care. Its approach to meeting his needs has clearly been budget driven and not needs driven. Its social worker and managers have made statements, quoted above, to both Ms B and to us. The Council based its approach on what respite care Mr C needed by measuring against a benchmark of what is provided by way of a national average, or average in the Council's area."

4.15 The Council did not carry out adequate care planning in this case. In particular we note the only evidence of a carer's assessment for Ms B was that completed as a 'parent-carer'. That was fault.

5. ALTERNATIVE OPTIONS CONSIDERED

N/A

6. CONSULTATION – ACTIONS TAKEN AND LESSONS LEARNT

Following receipt of the Ombudsman report the following actions have been taken:

6.1 A significant amount of work has been completed in Children's Social Care in relation to provision of support and care packages, a Care Provider Register is now in place. A review of the provision of suitable respite services and short breaks is underway that will further inform service development.

6.2 Local Authority has apologised to Mr B and her son Mr C for the failings identified in this report.

6.3 The Local Authority has made the compensatory payments recommended by the Ombudsman to Ms B.

6.4 Mr C has had a further reassessment of his needs and consideration was also given to the wishes of Ms B who was his informal carer. Mr C has subsequently moved to a 52-week residential educational placement. This move has superseded the need to review his personal budget.

6.5 Our Complaints Team has reviewed its practices and it will ensure that families, who wish to take their complaints further will be responded to in a timely manner.

6.6 All staff within the Transitions Service have now attended refresher training on person-centred and needs led care planning.

6.7 The LGO recommendations are clear, and the Council has already taken steps to improve practice in many areas as below:

i) Provision of respite care for children. LGO commented on the lack of evidence and efforts made to secure an alternative provision. Once children are assessed as needing short breaks away from home, referrals to relevant settings are managed through the Council's Placement Team. This will provide better assurance, recording and oversight.

ii) The Council has a well regarded Short-break Unit for Children with Disabilities (0-17). During 2020-2021 due to Covid restriction and the complexity of children's needs, the home could not be used to its full potential. This is now no longer the case, and our Unit is continually improving and providing good quality care for our children

iii) Transition Service has been located since April 2021 within Adult Social Care, and continues to work together with Children Social Care to build on resources available to support children, young adults and their families in a seamless and joined up manner. Mr C's circumstances were during a period of changes for both Children and Adult Social Care services. Processes and practice in a now settled service will now address the findings of the LGO.

iv) Education Health Care Plans (EHCP) – timely reviews are required when education provisions are no longer available, so that holistic support is considered by all those who have a statutory responsibility to support children.

v) The Council agrees that it has to work in a more inclusive ways with parents, so they can understand how decisions are made and they participate as equal partners in these decisions.

vi) The Council has recently employed a Senior Commissioner who is specialized in Disabilities and Autism. The Head of Service for Disability will be setting up a collaborative team which would include representatives from LD Health Team, Commissioning, Housing, and Provider Services to explore options for ensuring availability of respite placements for young adults with complex health and behavioural needs.

vii) All staff within the Transitions Service have recently attended refresher training on person-centred and needs led care planning.

viii) Supervision, evaluated through audits, will ensure staff are reminded and understand the importance of person-centred practice, keeping people using services central to the process and ensuring appropriate and timely support to carers.

ix) The current Carers' Strategy is being refreshed to improve the offer to carers.

x) The anonymised case will be used as a 'live' example to share with the Directorates Senior Management Team, to share lessons learnt.

The LGO investigation and recommendations serve as a reminder of the importance of regular training and workshops to front line practitioners with a focus on the need for safe care for children, young people and families and ensure that these are prioritised in assessments and balanced against all other responsibilities they have as council employees.

In future the Council will be more proactive in explaining its responsibilities to the LGO of meeting an individual's assess eligible need under the Care Act 2014 to achieve the best outcomes at the best value.

7. CONTRIBUTION TO COUNCIL PRIORITIES

N/A

8. IMPLICATIONS

8.1 FINANCIAL IMPLICATIONS

8.1.1 The financial recommendations made by the LGSCO were: £4000 in respect of compensation.

Approved by:

8.2 LEGAL IMPLICATIONS

8.2.1 Under the Local Government Act 1974 (the Act), the LGSCO has the power to investigate the complaint and to issue a report where there has been maladministration causing injustice; a failure in a service that it was the Council's function to provide; and a total failure to provide such service. The LGSCO has the power to make recommendations to the Council on how to improve its services and to

put things right for the complainant. However, these recommendations are not mandatory and the Council does not have to accept or follow them.

8.2.2 Within 2 weeks of receiving the LGSCO's report, the Council is required to give public notice by advertisements in newspapers stating that copies of the report will be available to inspect by the public at the Council's offices for a period of three weeks (s.30 of the Government Act 1974).

8.2.3 The Act provides that the report shall be laid before the "authority" for consideration. In the case of a local authority operating executive arrangements, "the authority" includes the executive which under current governance arrangements means the Directly Elected Mayor and Cabinet (s.25 (4) and (4ZA) Local Government Act 1974).

8.2.4 Where a finding of 'maladministration' is made the Council's Monitoring Officer is obliged to prepare a report for the Executive following the LGSCO findings and to consult with the Head of Paid Service and Chief Finance Officer for this purpose. This report must also be sent to each member of the Council and the Executive must meet within 21 days thereafter. The implementation of the proposal or decision must be suspended until after the report has been considered by the Executive (s.5A Local Government and Housing Act 1989). The Executive is required to consider this Monitoring Officer report on the findings of and response to the LGSCO's report.

8.2.5 Where the Executive considers a LGSCO's report and it is considered that a payment should be made or other benefit given to a person who has suffered injustice, such expenditure may be incurred as appears appropriate (s.31(3) Local Government Act 1974)

8.2.6 Within 3 months of receiving the LGSCO's report or such longer period as may be agreed in writing with the LGSCO, the Council must notify the LGSCO of the action which the Council have taken or propose to take (s.31(2) Local Government Act 1974). If the LGSCO is not satisfied with the action which the Council has taken or propose to take, the LGSCO shall make a further report. The LGSCO can also require the Council to make a public statement in any two editions of a newspaper circulating the area within a fortnight (s.31(2A) and (2D) Local Government Act 1974).

8.2.7 An Ombudsman's report should not normally name or identify any person (s.30 Local Government Act 1974). Therefore, the complainant should not be referred to by name and officers are not identified.

Approved by: Sandra Herbert, Head of Litigation & Corporate Law, on behalf of the Director of Legal Services and Monitoring Officer.

8.3 EQUALITIES IMPLICATIONS

8.3.1 The Council has a statutory duty to comply with the provisions set out in the Sec 149 Equality Act 2010. The Council must therefore have due regard to:
(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
(b)advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
(c)foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

8.3.2 Due consideration should be given to residents who may need to be treated even more favourably under the Equality Act 2010. These include disabled residents, parents/carers of disabled people and others who do not have English as a first language. Any action which treats a Disabled person/parent/carer more favourably does not constitute discrimination under Equality Act 2010.

8.3.3 The Council owes a duty of care to the parents/carers of Disabled people, through lessons learned it has now increased the capacity of staff to provide a responsive and sensitive service to carers through in staff training and the review and development of the carers strategy. It is anticipated that these changes will increases the levels of satisfaction experienced by service users.

Approved by:

Denise McCausland - Equality Programme Manager

9. APPENDICES

9.1 Appendix A – Full Ombudsman Report

BACKGROUND DOCUMENTS

N/A

10. URGENCY

N/A