

# CABINET 20 JULY 2017

# OMBUDSMAN REPORT - ADULT SOCIAL CARE

#### **Relevant Cabinet Member**

Mr A I Hardman

#### **Relevant Officer**

**Director of Adult Services** 

#### Recommendation

- 1. The Head of Legal and Democratic Services recommends that Cabinet:
  - (a) notes the adverse Ombudsman report in relation to Mr B, published on 15 June 2017;
  - (b) endorses the response of the Director of Adult Services to the Ombudsman's finding of maladministration; and
  - (c) authorises the Director of Adult Services to take all appropriate steps to address the issues raised in the Ombudsman's report.

#### The Local Government Ombudsman

- 2. The Ombudsman operates under the Local Government Act 1974 to investigate complaints that local authorities etc have acted in a way which amounts to 'maladministration'. The term is not expressly defined but the Local Government Ombudsman investigates and reports on complaints from members of the public who claim to have sustained injustice as a result of maladministration. Maladministration can encompass a number of failings by an authority, including inattention, neglect and delay.
- 3. The Ombudsman issues decision notices in respect of complaints made, whether upheld or dismissed, and in certain cases the Ombudsman publishes a full report. The Ombudsman published a full report on 15 June 2017 finding maladministration causing injustice following a complaint made by Mr B in respect of his mother Mrs C. The publication of a full report has not happened with this Council for a number of years, but if a full report is published then the authority must issue notices in the local media and the Monitoring Officer reports the finding to the Cabinet (if in relation to an executive function), copied to all members of the Council.
- 4. The Ombudsman in this case has asked that the report be considered at Cabinet and to be told within 3 months of receipt of the action the Council has taken or proposes to take.

### **Executive Summary**

- 5. Mr B complained the Council withdrew funding for his late mother's nursing care despite knowing that no-one had authority to deal with her financial affairs. Mr B also complained the Care Provider company then increased the charges for his mother's care without good reason and failed to deliver the care charged for. He complained the Council did not intervene effectively to ensure it paid the increased charge or challenge the price increase.
- 6. The Ombudsman found Fault causing injustice and recommendations were made for the Council to action within 20 working days of the report.
- 7. The Council has already confirmed it will comply with those recommendations to remedy the injustice found by the Ombudsman. However, Cabinet is asked to endorse that response of the Director of Adult Services.

#### **Ombudsman recommendations**

- The Ombudsman recommended that the Council should:
  - (a) apologise to Mr B for the failings identified in this investigation;
  - (b) pay Mr B £1000 in recognition of the distress caused by its actions;
  - (c) arrange with the Care Provider for it to re-issue invoices for the care provided to Mrs C for the period 1 March 2015 to the date of her death in August 2015 removing the £700 charge made for one-to-one care; the Council should ensure whatever credit appears on the account is refunded to Mrs C's estate (it is a matter between the Care Provider and the Council whether the Care Provider refunds the Council any money in turn).

and in addition demonstrate it has learnt lessons from this complaint. The Ombudsman set out some minimum expectations of what those lessons should be in the body of the report, and recommended the Council write to the Ombudsman within three months setting out the action it has taken or proposes to take further to any review it conducts into this matter.

### **Response of the Director of Adult Services**

9. The Director of Adult Services has accepted the recommendations. The Director has acknowledged that the practices at the time and the subsequent actions by the Council and the provider were not adequate and has sent a written apology to Mr B and has paid the £1000 in recognition of the distress caused. With respect to recommendation [c], this is being actioned and will be remedied as soon as practical. An Action Plan has been drawn up to address the areas referenced in paragraph 68 of the report and follow-up report to the Ombudsman will be supplied by 31 August 2017.

### Legal, Financial and HR Implications

10. The Ombudsman's finding is being reported to members in accordance with the Local Government and Housing Act 1989. Ombudsmen findings are not legally binding on authorities or enforceable as such although a second report can be published by the Ombudsman if not satisfied with the authority's response. However, they are independent investigations and in this case the Director has accepted the recommendations. The Chief Executive and Chief Financial Officer have been consulted on this report in line with the legislation.

### **Privacy and Public Health Impact Assessments**

11. There are no Privacy or Public Health implications from this report.

## **Equality and Diversity Implications**

12. The Ombudsman report addresses failings with regard to a service user without capacity and makes recommendations to address the issue more generally.

## **Supporting Information**

• Appendix – Ombudsman report in respect of Mr B's complaint (available on-line)

#### **Contact Points**

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#### **Background Papers**

In the opinion of the proper officer (in this case the Head of Legal and Democratic Services) there are no background papers relating to the subject matter of this report.