Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint about Rotherham Metropolitan Borough Council (reference number: 21 001 468)

28 Feburary 2022

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 X	The complainant
Mrs Y	The complainant's mother and close friend of Mr P
Mr P	The complainant's step-father and friend of Mrs Y

Report summary

Adult social care

Miss X and Mrs Y complained the Council:

- stopped them from seeing, Mr P, who Miss X considers to be her step-father, when he was in hospital and in a care home. They say the Council has not explained why they were not allowed to visit Mr P;
- stopped them from giving Mr P his personal belongings; and
- took safeguarding action against them but did not tell them what it was for at the time.

Miss X and Mrs Y say the Council's actions have caused them distress and frustration because they were only allowed to see Mr P for a short time before he died.

Finding

Fault found causing injustice and recommendations made.

Recommendations

To remedy the injustice caused by the faults identified, the Council has agreed to:

- apologise to Miss X and Mrs Y for the distress and uncertainty caused by the faults identified;
- pay Miss X and Mrs Y £600 each to acknowledge the significant distress and uncertainty caused by the faults identified;
- remind relevant staff of the importance of ensuring decisions are made in the best interest of the individual, and of keeping clear and accurate records of the process of working out the best interest of the person for each relevant decision. The records should detail the considerations listed within the code of practice. It is open to the Council to decide how to do this. However, we will require evidence of this being done;
- remind relevant staff of their duties under the Human Rights Act 1998. Again, it is open to the Council to decide how to do this. However, we will require evidence of this being done; and
- review its safeguarding procedures to ensure:
    - there is a clear process for producing safeguarding plans where appropriate; and
    - the alleged victim is properly involved in the safeguarding process, with an advocate appointed to support them if necessary.

The Council will tell us what action it will take to ensure relevant staff are familiar with any revised policies and procedures.

The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet or other appropriately delegated committee of elected members

and we will require evidence of this. (Local Government Act 1974, section 31(2), as amended)

The complaint

1. Miss X and Mrs Y complained the Council:

   - stopped them from seeing, Mr P, who Miss X considers to be her step-father, when he was in hospital and in a care home. They say the Council has not explained why they were not allowed to visit Mr P;
   - stopped them from giving Mr P his personal belongings; and
   - took safeguarding action against them but did not tell them what it was for at the time.

2. Miss X and Mrs Y say the Council's actions have caused them distress and frustration because they were only allowed to see Mr P for a short time before he died.

Legal and administrative background

The Ombudsman's role and powers

3. 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)***

4. This complaint involves events that occurred during the COVID-19 pandemic. The Government introduced a range of new and frequently updated rules and guidance during this time. We can consider whether the council followed the relevant legislation, guidance and our published "Good Administrative Practice during the response to COVID-19".

Relevant law and guidance

Human Rights Act

5. The Human Rights Act 1998 sets out the fundamental rights and freedoms that everyone in the UK is entitled to. The Act requires all local authorities to respect and protect an individual's rights.

6. The Act sets out the human rights in a series of Articles and each Article deals with a different right. Article 8 sets out the right for respect for private and family life.

7. Not all rights operate in the same way. Instead, they break down into three separate categories.

   - Absolute rights: those which cannot be taken away under any circumstances.
   - Limited rights: those that can be taken away in certain circumstances.
   - Qualified rights: those rights where interference may be justified to protect the rights of others or wider public interest. Any interference with a qualified right must be in accordance with the law, in pursuit of a legitimate aim, no more than necessary to achieve the intended objective, and must not be arbitrary or unfair.

8. The right to private and family life is a qualified right.

9. We cannot decide whether a council has breached the Human Rights Act. This can only be done by the courts. However, we can decide whether a council has had due regard to an individual's human rights in their treatment of them, when we consider a complaint.

10. In practical terms, councils will often be able to show they have complied with the Human Rights Act if:

- it can show they have considered the impact their decisions will have on the individuals affected; and
- there is a process for decisions to be challenged by a review or appeal.

Adult safeguarding

11. The Care Act 2014 provides the key legal framework for adult safeguarding. It gives Councils the lead responsibility for managing safeguarding concerns, determining safeguarding duties and undertaking safeguarding enquiries. The Care and Support Statutory guidance also provides councils with guidance on how to respond to safeguarding concerns.

12. The Council's safeguarding duties apply to adults who:

- have needs for care and support;
- are experiencing, or at risk of, abuse or neglect; and
- because of those care and support needs cannot protect themselves from either the risk of, or the experience of abuse or neglect.

13. Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. ***(Care and support statutory guidance, paragraph 14.7)***

14. The aims of adult safeguarding include:

- to prevent harm and reduce the risk of abuse or neglect to adults with care and support needs;
- stop abuse or neglect wherever possible; and
- safeguard adults in a way that supports them in making choices and having control about how they want to live.

15. The Care Act requires councils to make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should find out whether any action needs to be taken to prevent or stop abuse or neglect and if so, by who. The council should involve any relevant partners, such as the Police or NHS, and other persons relevant to the case.

16. An enquiry is the action taken, or instigated, by the local authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the individual who is the subject of concern, to a much more formal multi-agency arrangement. Whatever the course of subsequent action, the professional concerned should record the concern, the adult's views, wishes, and any immediate action taken and the reasons for those actions. ***(Care and support statutory guidance, paragraph 14.77)***

17. The adult should be involved from the beginning of the enquiry unless there are exceptional circumstances that would increase the risk of abuse. If the adult has substantial difficulty in being involved, and where there is no one appropriate to support them, then the council must arrange for an independent advocate to

represent them to facilitate their involvement. ***(Care and support statutory guidance, paragraph 14.80)***

18. Once enquiries are completed, the council should decide with the adult what, if any, further action is necessary and acceptable.

Mental Capacity Act

19. The Mental Capacity Act 2005 provides a statutory framework for people who lack capacity to make decisions for themselves. It sets out who can take decisions, in what situations, and how they should go about this. The Mental Capacity code of practice provides further guidance on applying the Act.

20. Chapter 5 of the Mental Capacity code of practice notes one of the key principles of the Act is that any act done for, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person's best interests.

21. The code of practice notes the act places a duty on the decision-maker to consult other people close to a person who lacks capacity, where practical and appropriate, on decisions affecting the person and what might be in the person's best interest. The decision maker has a duty to consider the views of the following people, where it is practical and appropriate to do so.

- Anyone the person has previously named as someone they want to be consulted.
- Anyone involved in caring for the person.
- Anyone interested in their welfare (for example, family carers, other close relatives, or an advocate already working with the person).

22. Decision makers must show they have thought carefully about who to speak to. If it is practical and appropriate to speak to the above people, they must do so and must take their views into account. They must be able to explain why they did not speak to a particular person, and it is good practice to have a clear record of their reasons.

23. When working out what is in the best interests of the person who lacks capacity to make a decision or act for themselves, decision makers must take into account all relevant factors that it would be reasonable to consider, not just those that they think are important. They must not act or make a decision based on what they would want to do if they were the person who lacked capacity. (***Mental Capacity Act 2005 Code of Practice section 5.7)***

24. Section 4 of the Act sets out some common factors that must always be considered when trying to work out someone's best interests.

- Working out what is in someone's best interests cannot be based simply on someone's age, appearance, condition or behaviour.
- Considering all relevant circumstances when working out someone's best interests
- Making every effort to encourage and enable the person who lacks capacity to take part in making the decision.
- If there is a chance the person will regain the capacity to make a particular decision, then it may be possible to put off the decision until later if it is not urgent.
- Taking into account the person's past and present wishes and feelings, beliefs and values.

- Considering the views of other people who are close to the person who lacks capacity.

25. Any staff involved in the care of a person who lacks capacity should make sure a record is kept of the process of working out the best interests of that person for each relevant decision, setting out:
    - how the decision about the person's best interests was reached;
    - what the reasons for reaching the decision were;
    - who was consulted to help work out best interests; and
    - what particular factors were taken into account.

How we considered this complaint

26. We spoke with Miss X and considered the information she provided.
27. We made enquiries with the Council and considered the information it provided.
28. We produced this report after examining relevant documents.
29. We gave the complainants and the Council a confidential draft of this report and considered their comments.

What we found

What happened

30. Miss X considers herself to be Mr P's stepdaughter. She said Mr P has been in her life since she was eight years old as he used to be her mother, Mrs Y's, partner. Mrs Y and Mr P are no longer together. Mr P has a diagnosis of dementia.
31. In 2015, the Council completed a carers assessment for Miss X as she was caring for Mr P. The case notes highlight Mr P was present for the assessment and reported to the social worker he was happy with the care he received from Miss X. The notes also highlight Miss X told the social worker she was happy to care for Mr P and that she would not put him in a home.
32. In August 2020, Mr P was in hospital. The Council received an anonymous referral on 18 August which raised safeguarding concerns for Mr P. The referral raised concerns about Miss X and Mrs Y.
33. The case notes showed the Council contacted the hospital to speak with Mr P about the referral. However, the hospital noted Mr P was very confused and would not have capacity to discuss the matter. The case notes also showed the Council had no other contacts for Mr P in its records other than Miss X and Mrs Y.
34. On 30 August, the Council completed a mental capacity assessment for Mr P. The assessment noted Mr P lacked capacity in relation to his care and support needs.
35. The Council contacted Miss X to discuss Mr P. Miss X told the Council she had been caring for Mr P for several years and was still happy to support him. Miss X told the Council she had asked for an assessment for a direct payment to become Mr P's personal assistant. The case note recorded that everyone agreed Mr P would be better at home.
36. On 1 September 2020, Miss X told the Council she had planned to source a private provider to support Mr P's discharge from hospital. This was due to delays

with the care being sourced by the Council. Miss X asked for the Council to send a social worker to the hospital to discuss the discharge planning.

37. The social worker attended the hospital the same day to complete a care assessment. The assessment noted Miss X supported Mr P with the assessment and that she had been his main carer for five years. It also noted Mr P did not have a power of attorney for his health, welfare, or finances. Miss X told the Council she was the appointee for Mr P's benefits and managed his bank accounts.

38. Miss X also told the Council Mr P had a biological daughter, but she was estranged from him. Mr P was not able to confirm this as he had no capacity. The care assessment noted Mr P had eligible care needs that had a significant impact on his wellbeing.

39. The records showed Miss X told the social worker she had sourced a care provider to provide care for Mr P at home. This was because she was not happy with the care he received from the hospital. The Council agreed to fund this initially through the COVID-19 fund, but that it would complete a financial assessment for Mr P when this funding stopped. Mr P was discharged from hospital to home.

40. On 4 September, the Council contacted its housing department who confirmed Mr P's property had not been a council property since June 2020. The housing department did not have any information about who had bought the property.

41. On the same day, the Council received concerns from one of Mr P's medical professionals about Mr P's safety in between care calls. The medical professional noted Mr P had fallen out of his chair and his dementia had deteriorated to the point where he is trying to get out of his chair and bed without support all the time. The medical professional also noted concerns Mr P was starting to show early signs of pressure area sores.

42. Following the concerns, the Council decided to refer Mr P to a care home. There is no evidence the social worker contacted Miss X and Mrs Y to inform them of the intention to move Mr P to a care home.

43. The Council received information that Miss X and Mrs Y were trying to stop Mr P from going to the care home. The social worker contacted Miss X and told her they had arranged for transport to pick Mr P up to take him to the care home. The social worker explained this was due to the concerns raised around Mr P's safety between care calls. The social worker told Miss X and Mrs Y they did not have a legal right to make decisions on Mr P's behalf.

44. Miss X said a district nurse had visited Mr P before he was due to move to the care home. As Mr P was in poor condition, Miss X called for an ambulance. Mr P was taken to hospital and admitted.

45. The Council contacted the hospital and told them to ask Miss X and Mrs Y to leave the hospital and for no information to be shared with them. Miss X told us she had tried to visit Mr P in hospital on the 5 and 6 September but that she was stopped from seeing him.

46. On 7 September, Mr P was medically fit to be discharged from hospital. The Council arranged for Mr P to be discharged to a care home. The Council contacted the care home and asked them not to share any information with Miss X and Mrs Y due to safeguarding concerns. The Council asked the care home to discard all contact details for Miss X and Mrs Y.

47. In line with government guidance in place at the time, the care home placed Mr P in isolation for 14 days. This was because he had been discharged from hospital to the care home.

48. On 8 September, the social worker made a referral for an advocate for Mr P. The social worker also spoke with Miss X to explain Mr Ps' biological daughter had asked the Council to tell the hospital not to allow them to visit. The social worker did not give Miss X any information about the safeguarding concern.

49. On 9 September, Miss X said the care home had contacted her and told her she was not allowed to visit the care home, or the police would be called. Miss X said she was not given a reason as to why she was not allowed to visit Mr P.

50. On 10 September, the Council received an email from the advocacy service to advise they were unable to see Mr P until the last week of September. This was because he was in isolation as he had just been discharged from hospital.

51. Between 11 and 16 September, Miss X said she contacted the Council to try and find out what was happening and why they had been stopped from seeing Mr P. Miss X said she found out Mr P was on end of life care on 16 September.

52. On 17 September, Miss X said she was allowed to see Mr P at the care home on supervised visits. Miss X said she was only allowed 30 minutes and was not allowed to give Mr P his clothes and personal belongings. Miss X told us she visited Mr P at the care home on 18 and 19 September.

53. On 20 September, Mr P died.

54. In September, the Council made a referral to the police in relation to the safeguarding concerns raised about Miss X and Mrs Y. The police told the Council it was not taking any further action as there was a lack of evidence to corroborate the allegations.

55. On 28 September, the social worker made enquiries with the Council's housing department to identify when Mr P's property had been purchased and whose name was on the property deeds. The Council spoke with Miss X to advise it was still completing enquiries about the safeguarding concerns.

56. On 2 October 2020, the Council received confirmation Mr P's property was owned by him and that it had been bought by gifted cash. The Council's housing department confirmed it had a form signed by the donor confirming the cash was a gift.

57. On 22 October 2020, Miss X provided bank statements for Mr P and confirmed Mrs Y had loaned the money to Mr P to buy the property. Miss X told the Council Mr P had agreed to leave the house to Mrs Y.

58. On 18 November 2020, the Council held a safeguarding meeting to discuss the information that was known so far. The Council discussed the matter of the house purchase and officers noted it was not known whether Mr P had capacity at the time the house was bought. The housing officer noted there was no evidence to suggest Mr P lacked capacity at the time of the application. It was agreed the Police would interview Miss X and Mrs Y about the concerns around the house purchase.

59. In December 2020, the Council chased the Police for an update.

60. In February 2021, Miss X asked the Council for an update on the safeguarding case. Miss X also tried to make a complaint about the Council's actions. An internal email noted Miss X was not actually Mr P's daughter.

61. In March 2021, the Council closed the safeguarding case as the Police had completed their investigation and declined to take any further action.

62. Miss X told us the Council's actions were significantly distressing for her and Mrs Y. This is because they felt like they had let Mr P down during the time he was in the care home. Miss X also said they had not been able to grieve for Mr P properly because the Council had not given them any reasons for why they were prevented from seeing Mr P between 5 and 16 September.

Analysis

63. It is clear there was a disagreement around whether Mr P should go to a care home. The evidence shows Miss X and Mrs Y were against the idea as they preferred Mr P to remain at home.

64. There is no evidence the Council completed a best interest decision for Mr P before deciding to move him to a care home. This was despite the Council assessing Mr P as lacking capacity to make decisions on his care and support needs. Given the conflicting views, the Council should have made a best interest decision in line with the Mental Capacity Act and the code of practice. This is fault.

65. The Council also delayed in arranging for an independent advocate to represent Mr P despite assessing him as lacking the capacity to make decisions about his care and support. The Council did not refer Mr P for an advocate until 8 September. This was not in line with the Act or the code of practice. This is fault.

66. The social worker told Miss X and Mrs Y they did not have a legal right to make decisions on Mr P's behalf. This was likely accurate. However, there is no evidence the Council considered whether it was practical and appropriate to consult with Miss X and Mrs Y in working out Mr P's best interest. It was relevant for the Council to consider this because it should have completed a best interest decision for Mr P before deciding to move him to a care home.

67. We consider the faults identified would have caused Miss X and Mrs Y distress and uncertainty. This is because they do not know if the Council made the decision in Mr P's best interest to move him to a care home. There is also uncertainty as to whether they would have had the opportunity to input into the best interest decision making as the Council did not consider whether it was practical and appropriate to consult with them.

68. The Council asked both the hospital and the care home to stop Miss X and Mrs Y from seeing or having contact with Mr P. The reason for this decision is recorded as being due to safeguarding concerns.

69. We accept safeguarding concerns had been raised against Miss X and Mrs Y. Councils should consider what steps they need to take to safeguard someone at the start of the process. If necessary, the Council can produce a safeguarding plan which could include moving someone to a place of safety, preventing contact with an alleged abuser, or arranging supervised contact.

70. We recognise that investigations and enquiries take time to complete. However, there is no evidence the Council considered what steps it needed to take to safeguard Mr P when it first received the concerns about Miss X and Mrs Y. There is no rationale as to why the Council decided it was necessary and appropriate to safeguard Mr P by preventing Miss X and Mrs Y from having contact with him. This is fault.

71. There is also no evidence the Council tried to seek Mr P's views or involvement in its safeguarding enquiries. Further, as the Council delayed in appointing Mr P an advocate, Mr P lost his opportunity to have his views and wishes represented at the start of the process. This is fault.

72. Therefore, it is not clear what evidence the Council considered before it decided it was appropriate to prevent access. It is also not clear what the Council's rationale and justification was to prevent contact. There is no evidence of a proper decision making process before the social worker asked both the hospital and care home to prevent Miss X and Mrs Y from having contact with Mr P.

73. Instead, it appears the Council just accepted the concerns raised at face value without further interrogation of the concerns raised. The Council only interrogated the information further after Mr P died, and after the decision made to prevent Miss X and Mrs Y from having contact with him. This is fault.

74. It is also relevant to highlight the Council agreed to supervised visits for Miss X and Mrs Y from 17 September onwards. It is not clear from the evidence why the Council made this decision and why it was now appropriate and safe for Mr P to have supervised visits with them. Again, the Council has failed to evidence it followed a proper decision making process as it is not clear what had changed after 16 September for the Council to make this decision. This also raises questions as to whether the Council could have made this decision earlier, instead of stopping all contact between Miss X, Mrs Y and Mr P. This is fault.

75. We note the matters being complained about would have happened during the height of the COVID-19 pandemic. At the time, government guidance was in place that required all residents who had been discharged from hospital to self-isolate in their room for 14 days. The care home confirmed it was following this guidance. Therefore, Mr P was required to self-isolate for his first two weeks in the care home.

76. As Mr P would not have been allowed visitors, Miss X and Mrs Y were not likely to have been able to visit him during his first two weeks in the care home, even if the Council had not prevented them from having contact with him.

77. Nevertheless, we consider the faults identified caused Miss X significant distress. This is because she was told she could not see Mr P, who Miss X considered to be her father, without a clear explanation for why. We also consider the fault identified caused Mrs Y distress as she was told she could not see her friend and ex-partner, without a clear explanation for why. The faults identified also caused them distress because they were later required to have supervised visits with Mr P without a clear explanation for why.

78. We also consider the Council failed to have due regard to the Human Rights Act, and in particular, Article 8. This is because the Council has not been able to demonstrate how it considered the potential impact of its decision to prevent access on Miss X, Mrs Y, or Mr P. The Council also did not tell Miss X or Mrs Y of the reasons for its decision. This would have made it very difficult for Miss X and Mrs Y to challenge the Council's decision.

79. Article 8 is a qualified right. This means this right can be interfered with when there is justification. It is clear Miss X and Mrs Y considered Mr P to be family, even though they are not related biologically. The Council has not been able to demonstrate its justification for interfering with Miss X and Mrs Y's Article 8 rights. We also consider the Council failed to have due regard to Mr P's Article 8 rights for the same reasons. This is fault.

80. We consider the fault identified caused Miss X and Mrs Y distress because there is uncertainty as to whether the Council had justified reasons for interfering with their Article 8 rights.

81. Finally, it is important to highlight Miss X made it clear to the Council from the start she considered Mr P to be her father. She was also open about the fact she was not biologically related to Mr P. There is also evidence Miss X had been caring for Mr P for over five years, which supports the fact Miss X had an established relationship with Mr P. There is no evidence the Council considered this.

82. Throughout the case records, the Council has left the impression it took the view Miss X was not Mr P's daughter simply because she was not biologically related to him. Therefore, there was no need to consider her views or to be mindful of what impact the Council's decisions had on her. We consider this to be an overly simplistic view of what makes a family. The Council should be mindful that families are diverse, and it is not necessary for someone to be related to another biologically to consider them family.

Recommendations

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

84. In addition to the requirements above, the Council has agreed to:

- apologise to Miss X and Mrs Y for the distress and uncertainty caused by the faults identified;
- pay Miss X and Mrs Y £600 each to acknowledge the significant distress and uncertainty caused by the faults identified;
- remind relevant staff of the importance of ensuring decisions are made in the best interest of the individual, and of keeping clear and accurate records of the process of working out the best interest of the person for each relevant decision. The records should detail the considerations listed within the code of practice. It is open to the Council to decide how to do this. However, we will require evidence of this being done;
- remind relevant staff of their duties under the Human Rights Act 1998. Again, it is open to the Council to decide how to do this. However, we will require evidence of this being done; and
- review its safeguarding procedures to ensure:
    - there is a clear process for producing safeguarding plans where appropriate; and
    - the alleged victim is properly involved in the safeguarding process, with an advocate appointed to support them if necessary.

  The Council will tell us what action it will take to ensure relevant staff are familiar with any revised policies and procedures.

Decision

85. We have completed our investigation into this complaint. There was fault by the Council which caused injustice to Miss X and Mrs Y. The Council has agreed to take the action identified in paragraphs 84 and 85 to remedy that injustice.