

## **Annual Local Government Ombudsman report to Cabinet 2020 - Appendix 2**

### **Summary of LGO decisions in relation to upheld complaints 2019-2020**

#### **1. Children's and families services complaints**

There were two cases upheld for children and family services in 2019/20. One of these was for social care and looked after children, and the other special educational services.

##### **1.1. Complaint 18001459**

###### **1.1.1. Complaint details**

The complaint states that the council failed to arrange contact between the complainant and their grandchildren who were subject to care proceedings. This was not investigated by the LGO as it was brought to their attention too late.

###### **1.1.2. Ombudsman findings**

The Ombudsman did not investigate the complaint about the council's decision to prevent contact between the family. They did consider the length of time that it took the council to deal with the complaint, and the incorrect information supplied regarding when complaints can be escalated when there are issues regarding permission, within statutory complaints processes.

###### **1.1.3. Recommendations and actions**

The council has made a payment to the family and apologised for delays and errors.

##### **1.2. Complaint 18001756**

###### **1.2.1. Complaint details**

The complaint reported several delays and failings from the SEND service, including not meeting agreed deadlines, and taking too long to commence work on actions agreed at a child protection meeting.

###### **1.2.2. Ombudsman findings**

The Ombudsman found several areas of fault causing injustice. It was found that professionals failed to work together cohesively for the family. This caused delays and confusion for the family. The council was criticised for not always ensuring that meetings are minuted, leaving the family facing confusion about what actions had been agreed. It was also found that, where minutes were taken, these were distributed too late to be helpful. The Ombudsman also found fault in that there was inconsistency in communication with the family throughout a worrying time for them, in particular there was no process to follow when key officers could not attend meetings. Finally, there was fault in that the council did not tell the family of their annual right to appeal for 5 years in a row. There were several faults identified in the case handling with this family, and the investigator concluded that the injustice would have been reduced significantly if the council had prioritised the family's needs 'holistically'.

###### **1.2.3. Recommendations and actions**

The council have apologised to the family, made a compensatory payment, and committed to a service review to improve procedures that link teams, in particular social care and education. The service area has also reviewed many processes as recommended. This included taking and distributing clear notes after all meetings, and making tribunal rights clearer in all communication

from the SEND service. A process has been introduced for tracking actions from meetings that officers are not able to attend. The Ombudsman was content with the actions taken.

## **2. Adult services complaints**

There were two complaints for adult services in 2019/20. These were both regarding at-home care for vulnerable and elderly residents, and involved external services that are commissioned by the council.

### **2.1. Complaint 18019376**

#### **2.1.1. Complaint details**

The complaint alleges that the council caused distress and anxiety for a vulnerable adult by failing to provide adequate night-time care through the reablement service. The complaint reported several occasions where a council-commissioned service had failed to properly provide care for the vulnerable adult, leaving them unable to safely use the toilet at night.

#### **2.1.2. Ombudsman findings**

It was found that the council acted quickly to deal with the original concerns and there was compliments to the social worker for their swiftness in making referrals. It was however also found that the lack of consistency to the service meant that there were at least 5 occasions where the complainant was left unable to use the toilet, after the council was first made aware of the problem. The council reported that it could not always arrange for staff to support the complainant as they needed high level training. The Ombudsman concluded that this was not a fair justification for failing to supply the entitled service. The complaint was upheld with a decision of 'fault with injustice'.

#### **2.1.3. Recommendations and actions**

To remedy the injustice, the council has apologised, and made a payment of £300. The service has carried out a review as recommended.

### **2.2. Complaint 18018122**

#### **2.2.1. Complaint details**

The complaint is against the council's handling of a contract with a third party service providing domiciliary and emergency care. The complainant said that, while the council had dealt with the problems raised through the complaints procedure well, they should have offered a better final resolution.

#### **2.2.2. Ombudsman findings**

The Ombudsman investigation found that the council investigated the complaint properly. It concluded that the council had found and resolved the fault in the commissioned service, and issued an appropriate apology. The council had made a payment to the complainant but the Ombudsman stated that they should have paid a greater sum of money in compensation as a highly vulnerable lady was at risk.

#### **2.2.3. Recommendations and actions**

The Ombudsman asked that the council continue to monitor the recommended actions from the previous report for the commissioned service. It has done this. The council has also made an additional payment to the complainant, as recommended by the Ombudsman. The complaints

officer has this year attended training regarding offering compensation payments and resolutions so that the council is better able to resolve complaints like this locally.

### **3. Highways complaints**

There were two complaints upheld following Ombudsman investigation within the highways department. One regarded traffic management planning for parking restrictions, and the second, a bus lane penalty.

#### **3.1. Complaint 18013914**

##### **3.1.1. Complaint details**

The complaint alleged that the council did not implement the parking design code that it agreed to do. It said that there was a safety risk by not restricting parking correctly.

##### **3.1.2. Ombudsman findings**

Implementing the parking restrictions took a long time to establish, up to 8 months in total. The Ombudsman considers this as unreasonable and a fault. The council held a meeting that the public was not invited to where it decided to halt the restrictions. There were no records of this meeting which is a fault, and caused injustice to the complainant. The Ombudsman did not agree that there were any safety risks during the delay. There were long delays in responding to the complaint, and the complainant often received no replies when contacting the highways team. The council was found to be at fault for causing uncertainty with a delay in developing a clear enforcement strategy.

##### **3.1.3. Recommendations and actions**

The parking restricted zone is now in place. It was not recommended that the council pay compensation, but a payment was made to the complainant to acknowledge the worry and stress of raising the complaint, and the delay at responding locally. The council has also apologised to the complainant.

#### **3.2. Complaint 18016440**

##### **3.2.1. Complaint details**

The complaint alleges that the council's failure to follow correct guidelines when using the DVLA's registered address caused significant financial cost and distress to the complainant.

##### **3.2.2. Ombudsman findings**

Through the local complaint process, the council said that it had to use the DVLA address at the time that the penalty charge notice (PCN) was issued, and could not change this. The Ombudsman confirmed that this was wrong, and the council can use the advised correct address. The error was fault, and caused the complainant to be fined over £400 by enforcement agents.

##### **3.2.3. Recommendations and actions**

The council has apologised, made a payment to cover the incorrect charge and distress caused, and changed the service policy to reflect the inaccuracy.

### **4. Planning**

There was one complaint upheld following Ombudsman investigation for the planning enforcement department.

#### **4.1. Complaint 17002757**

##### **4.1.1. Complaint details**

The complaint alleged that the council wrongly granted planning permission for an extension that blocked light to their kitchen.

##### **4.1.2. Ombudsman findings**

There were several faults found with the decisions taken by the planning enforcement team. This included not properly considering the complainant's points at the meetings. The committee was not properly informed, causing fault through injustice for the complainant. Finally, the council had agreed to investigate breach of planning under enforcement powers on more than one occasion without actually doing so.

##### **4.1.3. Recommendations and actions**

The council agreed to make a payment to the complainant, and commence necessary enforcement action. The planning department has also created new guidance around kitchens as habitable rooms.