Leeds CITY COUNCIL

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Report of Director of Adult Social Services

Report to Executive Board

Date: 04th January 2012

Subject: Public report of the Local Government Ombudsman regarding a complaint about a joint service provided by the Council and Leeds Community Healthcare NHS Trust

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ **Yes**	☒ No
Is the decision eligible for Call-In?	☒ Yes	☐ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This report provides details of a public report by the Local Government Ombudsman.

2. The report relates to a complaint about the Joint Care Management Service, a joint service located within the Leeds Community Healthcare NHS Trust as a delegated statutory function of the Council. The Council retains overall accountability for the statutory social care functions carried out by the joint service.

3. The events complained about took place between December 2008 and February 2009.

4. The Council and the LCH Trust have considered the Ombudsman's Report and have accepted the findings and recommendations. The Ombudsman has commended the positive response of the Council and the LCH Trust, and the commitment of both organisations to joint working and shared responsibility.

Recommendations

Members are asked to consider the reports and the actions taken by the Council to remedy the issues raised.

1. Purpose of this report

1.1 The purpose of this report is to inform Elected Members of a finding of maladministration with injustice, in a report issued by the Local Government Ombudsman.

2. Background information

2.1 Section 31(2) of the Local Government Act 1974 requires that where the Local Government Ombudsman issues a report with a finding of maladministration causing injustice, the Local Authority will consider the report. This requirement is fulfilled by reporting to the Executive Board.

2.2 The Ombudsman's findings must also be advertised in two newspapers and copies of the report made available for public inspection. In this case notices were placed in the Yorkshire Post and the Yorkshire Evening Post on 07th December 2011. The report was also made available at the city centre library and the main reception at Merrion House for three weeks commencing from 07th December 2011.

2.3 The full public report and Action Plan for this case is attached as appendix 1 and 2.

3 Main issues

3.1 Ms B complained that officers from the Joint Care Management Service delayed in responding to her concerns that her mother's nursing home, acting upon the instructions of her brother, had prevented her from visiting her mother. As a result of delays in resolving the situation by the time Ms B was able to visit her mother had suffered a stroke and was unable to recognise her. Her mother died the next day.

3.2 An internal joint investigation by the Council and LCH Trust upheld all of Ms Bs complaints bar one. The internal investigation did not uphold a complaint about the service failing to challenge Ms B's brother or the care home about the restrictions they had imposed.

3.3 Ms B was dissatisfied with the Council's consideration of her complaint and asked the Ombudsman to investigate.

4 Ombudsman's findings

4.1 The Ombudsman found that the delays in resolving the situation amounted to maladministration. The Ombudsman found that officers from the service failed to respond to nine contacts from Ms B and this also was maladministration.

4.2 The Ombudsman found that Ms B had suffered the injustice of being deprived of the opportunity to speak with her mother before she died.

4.3 The Council and the LCH Trust have accepted in full the Ombudsman's recommendations:

- To make a full written apology to Ms B;

- to pay for a memorial bench with an inscription in a location of Ms B's choice;
- to help Ms B find out where her mother was laid to rest;
- pay Ms B £5,000 in recognition of the distress caused to her.

4.4 As a result of the Council's internal investigation a comprehensive management action plan had already been drawn up. The Ombudsman found that all the recommendations from the internal investigation had been implemented and made no further recommendations. The attached action plan therefore informs members of the actions taken in response to both the internal investigation and the Ombudsman's report.

4.5 The Ombudsman has commended the positive response of the Council and the LCH Trust, and the commitment of both organisations to joint working and shared responsibility.

4.6 The Director of Adult Social Services and the Chief Executive of LCH Trust have provided an unreserved apology in recognition of the distress caused to Ms B and has assured her that while the errors cannot been undone the remedies are offered in the spirit of sincere regret.

5. Corporate Considerations

5.1 Consultation and Engagement

5.1.1 It is regrettable that this case represents an individual occasion where the standards expected for consultation and engagement with a service users family were not achieved, resulting in a tragic outcome. There is no indication that this is other than an isolated incident. However, the implementation of the attached action plan will further strengthen practice.

5.1.2 In conducting the investigation into the circumstances extensive consultation has taken place between the Ombudsman, the complainant, the local authority and the LCH Trust.

5.2 Equality and Diversity / Cohesion and Integration

5.2.2 This report does not request a decision that would have implications in these areas.

5.3 Council Policies and City Priorities

5.3.1 The complaint, and the Council and the LCH Trust's response to the Ombudsman's report, has provided opportunities to promote partnership working with the LCH Trust. Members will note paragraph 40 of the Ombudsman's report where it is stated that "The combined internal complaints process for the Joint Service worked well…The Council and the Trust also responded positively to the draft of this report and demonstrated and impressive commitment to joint working and shared responsibility."

5.4 Resources and Value for Money

5.4.1 A one off payment of £5,000 has been made and the Directorate has undertaken to erect an inscribed memorial bench. These remedies were offered after taking the advice of the Ombudsman and are believed to offer best value in concluding the complaint and mitigating any future costs should the complainant pursue a legal claim. The Director of Adult Social Services has secured the agreement of the LCH Trust to contribute 50% towards the compensation payment. Members will note that the Ombudsman has commended the Council and the LCH Trust for responding positively to her report. The Directorate has been keen to adopt a positive stance in order to offset, and avoid any further, negative publicity.

5.5 Legal Implications, Access to Information and Call In

5.5.1 The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009) place a duty on Councils and the NHS to establish and implement a procedure for dealing with complaints and representations. The complaints procedure is a two-stage process, the first stage being consideration by the Council, and the second being investigation by the Health or Local Government Ombudsman.

A person is eligible to make a complaint under the statutory complaints procedure where the Local Authority and the Health Service have a power or duty to provide or secure a service.

5.5.2 The courts would normally expect a complainant to have exhausted the statutory complaints process before initiating legal proceedings. It is possible that the complainant will take the admission of liability provided by this complaint outcome as grounds to make a legal claim. As the Council retains the statutory responsibility for the service provided by the Joint Care Management Team the liability for any settlement would remain with the Council (and not the LCH Trust). Should the complainant choose to make a legal claim the Council would submit its acceptance in full of the Ombudsman's recommendations as mitigation for any further financial settlement.

5.5.3 The Ombudsman's report does not contain the complainants full name and the report is a public document. The Council has fulfilled it's obligations to publicise the report.

5.6 Risk Management

5.6.1 The decision to accept in full the recommendations made by the Ombudsman was made after considering the risk of reputational damage to the Council and of the potential for future legal proceedings.

6. Conclusions

6.1 The Ombudsman's proposed remedies have been implemented immediately where possible or form part of the longer term action plan.

6.2 A detailed action plan is in place. Details are attached.

7. Recommendations

7.1 Members are requested to:

- Receive and note the Ombudsman's Report and findings and the Council's response.
- Note that this case dates back as far as 2008 and since then the Council has provided a significant training programme to workers in the areas of Safeguarding Vulnerable Adults and the Mental Capacity Act.

8. Background documents

None.