Appendix 2

21 September 2016

Complaint reference:
16 001 126

Complaint against:
Bath and North East Somerset Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: The complaint is upheld. The Council did not follow its policy when deciding to treat Mr B as a vexatious complainer. As the restriction will expire shortly no further action is necessary.

The complaint

1. Mr B complains about the Council's decision to consider him a vexatious complainant. He considers the Council did not follow the proper process before reaching the decision and the evidence did not support him being considered to be vexatious.

The Ombudsman's role and powers

2. The Ombudsman investigates complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. She provides a free service, but must use public money carefully. She may decide not to start or continue with an investigation if she believes:

- the fault has not caused injustice to the person who complained, or
- the injustice is not significant enough to justify the cost of her involvement, or
- she cannot achieve the outcome someone wants.

(Local Government Act 1974, section 24A(6))

How I considered this complaint

3. I considered the complaint and spoke to Mr B. I asked the Council for its comments on the complaint and additional information. I sent a copy of a draft of this statement to Mr B and the Council and invited their comments.

What I found

Factual background

4. The Council said it considered Mr B's correspondence met the criteria for being a vexatious complainer. It said:

- Mr B had persistently made complaints where he had already received an answer. It referred to one complaint where the Council had wrongly erected a road sign which projected over Mr B's land;
- when he had received an answer he would raise a slightly different issue or question or request information or pursue the complaint through other means. The Council referred to the same complaint about the road sign;

- Mr B's contacts with the Council were excessive in the number of emails and those emails were sent and copied to numerous officers;
- he had verged on rudeness, been sarcastic and made threats to officers.

5. The Council said that before it made a decision on whether to class him as a vexatious complainer Mr B could make comments.

6. Mr B replied, his main point was that he wanted the Council to provide evidence in support of its comments. He said he could not reply until he had that detail from the Council.

7. The Council wrote to him again saying that he would be classed as a vexatious complainer and he should send all future correspondence to one named point of contact. The officer referred to Mr B's numerous complaints and commented that Mr B's correspondence was often abusive, aggressive and harassing. The Council said it would read all letters, but only reply if it judged a reply was needed. The Council would review the decision after six months.

8. Mr B disagrees with the Council's decision and says he has kept to the Council's complaints procedure. Mr B says the Council has made him a vexatious complainant to prevent him questioning it further. Mr B wants the Council to remove the restriction so he can continue to pursue complaints.

Assessment

9. The Council's policy on when it will consider a complaint to be vexatious states that if it considers that a person has habitually, persistently and without reasonable grounds, made vexatious complaints in accordance with the policy criteria, either against the same or different Council officers and services, the matter will be referred to the Monitoring Officer. The Monitoring Officer will investigate the referral, including monitoring whether the number of complaints received by a department are unacceptably high or had suddenly risen.

10. I do not consider the Council followed its policy when deciding that Mr B should be treated as a vexatious complainer. My understanding of the policy would be the where someone has made many complaints either to one department or across the Council. I consider the correspondence to Mr B explaining that he was to be deemed a vexatious complainer suggests that. The letter refers to numerous complaints. That is not what had happened. Rather Mr B had corresponded about two issues.

11. Even if it was considered that Mr B's correspondence on those two matters had reached a point where it could be considered to be excessive or vexatious that does not meet the requirements in the policy for deeming him to be overall a vexatious complainer. The policy explains the relevant criteria is that someone must habitually and persistently have made vexatious complaints. I do not consider that two complaints could meet that requirement and I do not consider the Council has demonstrated why it considered it did.

12. The Council has commented there is no requirement in the policy for the complaints to be about different matters; the issue is where there are numerous complaints that are vexatious in nature. I consider the policy as written would be understood to mean that distinct complaints were being raised. This was not the case and that is why I do not consider the Council followed the policy as it is written. I therefore consider it would be helpful if the Council reviewed its policy on how it treats unreasonable behaviour from complainants. We have produced guidance on this subject.

13. The restriction on the means by which Mr B can contact the Council will expire shortly after this statement is issued. I had considered that the Council should lift the restriction but as it will expire so soon there is nothing to be achieved by me pursuing this point further with the Council. Mr B has commented that he considers the Ombudsman should recommend the Council take other action to remedy his complaint. I have considered Mr B's points but I do not consider any remedy is warranted. Mr B could still raise any service issues with the Council while the restriction on contact was in place. He could also raise complaints and the Council would have had to consider how to consider them. Mr B has not suggested that he has not been provided with some service to which he was entitled or otherwise has not had a proper response from the Council to a matter of significance. I do not, therefore, consider that he has suffered any significant personal injustice that warrants any remedy.

14. It will be for the Council to decide how to respond to any further correspondence from Mr B. It is open to the Council to decide that it has provided a reasonable response on a particular issue and that it will not respond further. If Mr B was unhappy with a decision by the Council on how it responded then he can come to the Ombudsman.

Final decision

15. The complaint is upheld. The Council did not follow its policy when deciding to treat Mr B as a vexatious complainer. As the restriction will expire shortly no further action is necessary.

Investigator's decision on behalf of the Ombudsman

14 November 2016

Complaint reference:
16 006 313

Complaint against:
Bath and North East Somerset Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: The Council failed to respond to Mr B's complaint on several occasions within a reasonable period of time. As a result of these failures it delayed in taking action about the parking problems in his street.

The complaint

1. Mr B complains that Bath and North East Somerset Council (the Council), in respect of parking problems near his home, failed to:

- respond to his queries and communications within a reasonable period of time or within the timescales set out in its complaints procedure;
- respond to his queries about parking suspensions and enforcement visits;
- take prompt action to investigate the issues raised such as visiting the road; or,
- contact him regarding the planning issues as promised in its stage two response dated 27 April 2016.

The Ombudsman's role and powers

2. The Ombudsman investigates complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. She must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. If there has been fault which has caused an injustice, she may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1))***

How I considered this complaint

3. I have considered the complaint and the documents provided by the complainant made enquiries of the Council and considered the comments and documents the Council provided. I have also given the Council and the complainant a chance to comment on a draft of my decision.

What I found

Council's complaint policy

4. This policy says that the Council will acknowledge complaints within five working days and respond fully within 15 working days

What happened

5. Mr B lives on a road with a residents' parking scheme. He has no off-road parking and relies on the permit area to find parking near his home. The area allows non-residents to park for four hours in the bays.

6. In early 2015 building work started on a house near to Mr B's house. This work involved placing a temporary fence and traffic cones across several parking spaces, reducing the availability of parking in the road. Mr B said that on several occasions the nearest parking space was ¼ mile away.

7. In August 2015 he contacted the Council to ask if it had formally suspended the parking bays due to the building work. He received an automated acknowledgement but no reply. On 21 September 2015 he sent a second email. Again he received an acknowledgement but no reply. He then submitted a formal complaint on 29 October 2015. He didn't receive a reply. Instead he received a customer satisfaction request asking if he had been satisfied with the response to his original query.

8. Mr B contacted the Council to say he had not yet had any response to his original query or subsequent complaint correspondence. The Council sent a formal response on 25 November 2015. It apologised for the loss of his emails and the failure to respond. It said according to its records it had not identified any parking bay suspensions in place for longer than a few days. In terms of traders using the spaces for longer than they should, it said it did operate trade parking accounts enabling businesses to activate parking in resident zones across the city when needed to carry out building work. Although this did not involved physical permits, civil enforcement officers on patrol would check to see if the permits had been activated.

9. It said the patrol officers aimed to visit the area every day and complete at least two visits. But it said that due to staffing problems this may not have been achieved in recent months but it was currently training 19 new members of staff.

10. Mr B then asked for confirmation that no applications had been made for suspension of parking in the stretch of road outside the building site and gave details of cars parked for longer than the permitted time over the past two weeks.

11. The Council replied that it had only approved one parking suspension in the road since March 2015 and for a different area. It also said it had spoken to the highways department who confirmed it had not issued any licences for skips or building materials in the road since March 2015. It said it couldn't give information about specific vehicles but since August 2015 officers had made 128 visits and issued 43 penalty charge notices. In December 2015 Mr B informed the Council that the road was blocked by a mechanical digger, a trailer and two 'dump' bags.

12. Mr B did not receive a further reply. In February 2016 he asked for a review of his complaint and contacted his local councillor. He did not receive a reply so he wrote to the chief executive of the Council on 12 April 2016.

13. On 27 April 2016 the Council responded to Mr B. It said it was unable to trace his last email of 14 December 2015 nor his letter of 19 February 2016 which he had hand-delivered to the Council offices. It apologised for these failures. It said it had arranged for the civil enforcement officers to increase their presence in the area over the next few weeks and it would then review the situation. A

highways officer had visited the site on 22 April 2016 and would pursue the contractor regarding the need to obtain a hoarding licence (for the scaffolding obstructing the highway). It also said it was making some changes to the parking bays to allow the access to the property under development while compensating for the loss of parking in a slightly different area of the road. It also invited Mr B to comment on the four hour parking restriction as part of the review of the permit scheme. Finally the planning enforcement team would visit the site to check if there were any breaches of the planning permission in connection with the work. The officer would then contact Mr B with an update.

14. Mr B sent a further email saying that although action was now being taken it appeared there had been a potential loss of revenue for over six months due to the building work.

15. On 19 May 2016 the Council sent a final response to Mr B. It concluded that the matters originally raised had now been addressed but there were some learning points about the way the Council had failed to deal properly with his complaints since August 2015. Mr B replied in June 2016 saying he was dissatisfied with the level of action taken and it appeared that civil enforcement officers had not reported any problems in the road despite the obvious obstruction for months.

16. Mr B then complained to the Ombudsman. In response to my enquiries the Council said that civil enforcement officers visited Mr B's road on 278 occasions between 1 August 2015 and 30 April 2016 and issued 83 penalty charge notices. It has also provided figures for the period 27 November 2015 to 31 August 2016 saying these show an increase in visits and penalty charge notices. However as the two periods overlap I do not see how it can reach this conclusion.

17. It said officers were expected to report urgent issues which involved a health and safety concern or directly affected parking operations (such as holes, broken glass, walls, fences, fallen trees and unauthorised skips).

18. It said the highways department had written to the contractor on 27 July 2016 regarding the illegal hoarding/scaffolding on the public highway. The contractor submitted a retrospective licence application on 1 August 2016 paying a fee of £120. It said a planning officer had visited the site in May 2016 and not found any evidence to substantiate a breach of the construction management plan. It apologised for not updating Mr B about his conclusions.

Analysis

19. The Council failed to respond to Mr B's queries and complaints within a reasonable period of time between August 2015 and April 2016. It should have responded to his initial query within three weeks but it took three months. It then failed to respond to his email in December 2015 (which it acknowledged it received) and failed to respond to his complaint in February 2016 until April 2016. These repeated failures caused Mr B frustration as well as time and trouble in pursuing the matter when the Council failed to respond.

20. In terms of taking action over the issues raised I consider the Council took far too long to respond. Beyond an assurance to increase patrols in the area it did not visit the road or inspect the site until April 2016. This visit resulted in a change to the parking bays to increase the available parking. If the Council had taken action at an earlier stage then the changes could have been done in November 2015.

21. The Council also said in April 2016 that it would contact the contractor to ensure he applied for the correct licence. However there was then an inexplicable delay of three months in doing so. By the time it contacted the contractor he was almost ready to dismantle the scaffolding.

22. I am also concerned that despite the daily visits, there is no evidence that the civil enforcement officers reported the obstruction of the parking bays by the building work.

Agreed action

23. The Council has apologised to Mr B for the delay in responding to his complaints and the failure to take significant action in November 2015. I do not consider any further remedy is necessary because Mr B's main concern had been loss of revenue to the Council rather than any great difficulty in parking his car.

24. However I would ask the Council to:

- ensure that the promised improvements to its complaint handling have been implemented; and,
- to remind its civil enforcement officers of the requirement to notify the Council of any obstructions to the parking bays.

Final decision

25. I consider this is a reasonable way of resolving the complaint and I have completed my investigation on this basis.

Investigator's decision on behalf of the Ombudsman

30 August 2016

Complaint reference:
15 000 492

Complaint against:
Bath and North East Somerset Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: the Council failed to keep Mrs B up to date with what was happening with plans to reduce the height of a speed table and delayed. An apology, £500 compensation, a reminder to officers about the requirements in the regulations and a commitment to complete the works within three months is satisfactory remedy for the injustice caused.

The complaint

1. The complainant, whom I shall refer to as Mrs B complained the Council delayed taking action to reduce the height of the speed table outside her property. Mrs B says the speed table exceeds the regulation height and is causing noise and vibration. Mrs B says despite the Council agreeing to reduce the height of the speed table it has failed to do so. Mrs B says the Council also misled her about whether the completed works met the requirements of the regulations.

The Ombudsman's role and powers

2. The Ombudsman investigates complaints of fault where someone says it has caused them injustice. If the Ombudsman finds fault but no injustice, she will not ask a Council to provide a remedy. If she finds both fault and injustice, she may ask for a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1))***

3. The Ombudsman cannot investigate late complaints unless she decides there are good reasons. Late complaints are when someone takes more than 12 months to complain to the Ombudsman about something a Council has done. ***(Local Government Act 1974, sections 26B and 34D)***

How I considered this complaint

4. As part of the investigation, I have:

- considered the complaint and Mrs B's comments;
- made enquiries of the Council and considered the comments and documents the Council provided;
- considered Mrs B's comments on my draft decisions; and
- gave the Council an opportunity to comment on my draft decisions.

What I found

Chronology of the main events

5. The Council installed a speed table outside Mrs B's property in 2009. Mrs B says she contacted the Council about that due to vibration and noise in 2009. Mrs B says the Council said nothing could be done.

6. Mrs B continued to experience noise and vibration from the speed table and measured the height of it in 2014. At that point Mrs B realised the speed table was higher than the regulation height. Mrs B told the Council about that in 2014. The Council later measured the height of the speed table and found it was higher than the regulation height. The Council later told Mrs B it could build road layouts outside the standards and this was not illegal. Mrs B consulted the Department for Transport about that. The Department for Transport told Mrs B there was no tolerance allowed in the regulations.

7. The Council wrote to Mrs B in March 2015 to suggest four alternatives. Mrs B said she wanted the speed table removed. The Council explained that to remove the speed table it would first need to carry out consultation which would delay the process. The Council also said removing and rebuilding the speed table would require consultation. The Council agreed to refer the case to the Cabinet Member following local elections in May 2015. At around this time the parish council offered to complete the formal public consultation at its own expense. The Council did not respond to that offer.

8. In July 2015 the Cabinet member approved remedial works to reduce the height of the speed table.

9. In October 2015 the Council said it would carry out the work when other works in the area which it intended to complete by April 2016. However, when the Council completed the other works in March 2016 it did not reduce the height of the speed table. The Council says that is because reducing the height of the speed table would need a full road closure. The Council considered that would cause unacceptable disruption in the area if it was carried out when the other works took place.

10. The Council has now completed the design work to enable it to carry out the work to the speed table.

Analysis

11. I understand Mrs B first experienced problems when the speed table was installed in 2009. Mrs B says the Council told her at the time nothing could be done. I have not investigated back to 2009 because it is more than 12 months ago. I see no reason why Mrs B could not have contacted the Ombudsman within 12 months of the Council telling her nothing could be done. Given the passage of time and the fact the officer involved has now left the Council I do not consider any investigation I could now carry out into what happened between 2009 and 2014 could reach a safe conclusion. I have therefore not exercised the Ombudsman's discretion to investigate matters before 2014.

12. I am concerned though with what happened once the Council established the speed table exceeded the regulation height. I understand the Council had that information in August 2014. I would expect there to have then been a short delay while the Council considered how to resolve the problem. However, it was more than six months later when the Council came up with four options. I do not

consider that acceptable given the Council knew the speed table did not meet the regulation height. That delay is fault and has delayed completion of the works.

13. I do not criticise the Council for failing to reduce the height of the speed table as soon as it knew the speed table exceeded the regulation height though. As I said in the previous paragraph, I cannot criticise the Council for considering ways to resolve the matter, although I would have expected it to complete that process earlier. I am satisfied the Council did not pursue the proposals it came up with not due to fault, but because Mrs B said she wanted the table removed. As the Council made clear, removal would require consultation. I could not criticise the Council for failing to reduce the height of the table in the interim because if it then decided to remove the table after consultation it would have wasted public funds.

14. I am satisfied the Council made the decision to reduce the height of the speed table by July 2015. I am concerned about what happened after that. I do not criticise the Council for initially programming the work to take place at the same time as other works in the area. The Council told Mrs B on that basis the work would complete by April 2016. It is clear the work did not take place at the same time as other works for the area. I do not criticise the Council for that decision given it was concerned about additional disruption for local residents as reducing the height of the speed table would require a full road closure. However, I am concerned the Council failed to explain that to Mrs B. In addition, given the Council did not complete the design works until July 2016 it seems unlikely April 2016 was ever a realistic target.

15. I would, in any case, have expected the Council to complete the design work by March 2016 given its intention to complete the works at the same time as other works in the area. As the Council knew the works were required due to it installing the speed table at an incorrect height I consider it should have given priority to those works once the other works were completed. It now seems unlikely the works will complete much before the end of the summer 2016. While I could not say the works will remove any impact on Mrs B she is left not knowing whether the impact on her could have been alleviated at an earlier date. Given the length of time this has already been in progress I would also not want the situation to be allowed to drift. I therefore recommend the Council agree to complete the works to the speed table within three months of my final decision.

16. Mrs B says the Council inaccurately told her in 2015 taking out the existing table and rebuilding it to the correct height would require consultation. Mrs B says that cannot be right when the Council would only be installing a speed table that was at the right height. I understand Mrs B's concern about whether consultation was needed for replacing the speed table with one at the approved height. However, the point here is Mrs B had made clear she wanted the speed table removed. It is likely the Council was wrong to suggest it needed to consult on replacing the speed table with one at the correct height. However, I do not consider this caused any extra delay or further injustice to Mrs B. That is because the reason things did not progress at that point is because Mrs B said she wanted the speed table removed. There is no dispute the Council would have had to consult on that.

17. Mrs B says the Council is at fault for telling her in February 2015 it could build a speed table outside the regulation height when that is not the case. I understand Mrs B's concern about information provided by the Council. However, I am satisfied the Council put together four options to seek to resolve the matter one month later. So, whatever the Council officer said in February 2015 it did not affect the way the Council approached the case. Nevertheless, I recommend

those dealing with highway works are made aware of the parameters of what the Council can and cannot do when installing speed tables.

Agreed action

18. Within one month of my decision the Council should apologise to Mrs B for not keeping her up to date and for the delays and pay her £500 compensation. That is partly to reflect the time and trouble Mrs B had to go to pursuing her complaint. It is also to reflect the additional time Mrs B has had to put up with a speed table which exceeds the regulation height due to delay by the Council.

19. Within one month of my decision the Council should remind officers dealing with highways works of the regulations relating to the height of speed tables.

20. Within three months of my decision the Council should complete the work to reduce the height of the speed table.

Final decision

21. I have completed my investigation and found fault by the Council which caused Mrs B an injustice. I am satisfied the action the Council will take is sufficient to remedy her injustice.

Investigator's decision on behalf of the Ombudsman

31 March 2017

Complaint reference:
16 006 446

Complaint against:
Bath and North East Somerset Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: The Council failed to conduct two safeguarding investigations without fault and to ensure the terms of reference set reflected the correct evidential test that should be applied to the information gathered. That resulted in a loss of confidence in the decisions taken.

The complaint

1. In brief the complaint is when managing a safeguarding investigation the Council failed to:

- Properly conduct a safeguarding investigation leading it to uphold a complaint and launch a further safeguarding investigation;
- Properly set the terms of reference for the Chair of the review of the safeguarding investigation reflecting the civil test of 'balance of probability' leading the Chair to decide one complaint as 'inconclusive';
- Properly weigh evidence presented to the planning meetings during the safeguarding investigation and review.

2. The complainant, whom I shall refer to as Dr X, says this has led to an 'inconclusive' finding on a complaint he believes would have been upheld but for the failure to set the correct terms of reference. Dr X believes the Council should review the matter again. He believes the evidence all points to a finding of 'substantiated' on the complaint that providing 1:1 care would have reduced the risk of falling. Thus preventing injuries suffered by his late father, whom I shall refer to as Mr Y.

The Ombudsman's role and powers

3. The Ombudsman investigates complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. He must also consider whether any fault has had an adverse impact on the person making the complaint. I refer to this as 'injustice'. If there has been fault which has caused an injustice, he may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1))***

How I considered this complaint

4. In considering the complaint I have:

- Spoken to Dr X;
- Reviewed the information presented with the complaint;

- Put enquiries to the Council and reviewed its responses;
- Taken a statement from the Safeguarding Chair;
- Shared with Dr X and the Council my draft decision and reflected on comments and information received in response to that draft decision.

What I found

The Council's Safeguarding Police

5. The Council's Safeguarding Policy says the aim of adult safeguarding includes:

- Stopping abuse or neglect wherever possible;
- Preventing harm and reduce the risk of abuse or neglect to adults with care and support needs;
- Safeguarding adults in a way that supports them in making choices and having control about how they want to live;
- Address what has caused the abuse or neglect.

6. The purpose of safeguarding is then to prevent and stop any abuse or neglect or risk of such.

Safeguarding Procedure

7. The Council's procedure says the role of safeguarding planning meetings is to evaluate and decide the outcome of the allegation on the balance of probabilities. In doing so, the Chair must adhere to one of the four possible outcomes contained in the Information and Guidance for the Safeguarding of Adults. This guidance issued by the Health and Social Care Information Centre defines the possible outcomes as:

- Conclusion Fully Substantiated – all allegations happened on the balance of probabilities;
- Conclusion Partially Substantiated – some, not all allegations happened on the balance of probabilities;
- Conclusion Inconclusive – the evidence does not allow the decision maker to make a decision for example where it is one person's word against another's and there is no other corroborative evidence;
- Conclusion Not Substantiated – the allegations are not believed on the balance of probabilities;
- Investigation ended at individual's request.

8. The chair must then decide on action taken adhering to the four possible results set out in the Information and Guidance for the Safeguarding of Adults Return (SAR) issued by Government. Those are:

- No further action under safeguarding;
- Risk remains;
- Risk reduced;
- Risk removed.

Why there were two safeguarding investigations?

9. The Council says for several reasons its first investigation into safeguarding concerns about the care of Mr Y did not cover all the concerns. On the advice of

its independent complaints reviewer who found fault with the first investigation, it decided to conduct a further safeguarding investigation covering those concerns.

10. The Council says Dr X agreed the terms of reference for the second investigation at a two hour meeting with the proposed Chair of that investigation. The terms of reference state the investigation will review and analyse whether the allegation of neglect [of Mr Y] could be substantiated if the following were identified:

- " i) The falls risk assessment and/or consequent falls prevention strategies were inadequate; and/or
- ii) [Mr Y] continued to require 1:1 supervision: whether for his falls risk or some other reason; and/or
- iii) [Mr Y's] fall on 24 December 2013, or some other occurrence that caused [Mr Y] harm would not have happened had [Mr Y] received 1:1 supervision".

11. Mr X says it is in this third term of reference the Council failed to direct the investigation to the correct evidential test. The Council's complaints reviewer agreed when she completed her review of the second safeguarding investigation.

Background to the complaint

12. Dr X's father, Mr Y, lived in a care home funded by NHS Continuing Care. Between November 2012 and December 2013 Mr Y experienced falls in the home. The care home and managers of Mr Y's care decided he should have 1:1 night time care from January 2013. Mr Y needed help managing his agitation and distress during the night, which when not managed resulted in him walking around his room and going into other resident's rooms causing them distress. As a non sighted man this put him at risk of falling.

13. In July 2013 the care home changed Mr Y's care regime. It stopped providing 1:1 night-time care. It decided he needed 1:1 daytime care. It did not consult Dr X or the funding body on this change.

14. At the annual review of Mr Y's care in October 2013 Dr X learned the 1:1 night-time care had stopped in July 2013. Dr X says he received no explanation. The records do not show any challenge by the funding authority responsible for Mr Y's care.

15. On 24 December 2013 Mr Y fell during the night suffering injuries. Dr X says that but for the failure to provide 1:1 care Mr Y's fall would have been prevented. Mr Y passed away on 3 January 2014.

16. The NHS provided care to Mr Y and therefore had responsibility for its management. The Council has responsibility for the investigations into concerns about safeguarding.

Safeguarding investigations

17. The Council undertook two safeguarding investigations because its first investigation did not cover all the concerns raised. That first investigation followed the safeguarding alert received by the Council on 6 January 2014 following Mr Y's fall on 24 December 2013. The safeguarding investigation began with a multi agency planning meeting attended by Dr X.

18. In April 2014 the Council discussed the terms of reference for the safeguarding investigation. It decided it would investigate whether there had been neglect resulting in significant harm to Mr Y while living at the care home. The investigation would visit the home, review Mr Y's case notes and compare information with that provided by Dr X. The investigation would:

- Establish if the Care Provider provided the 1:1 care it says it provided between 31 October 2013 and 24 December 2013;
- Review Mr Y's care between 21 July 2013 and 24 December 2013 to identify any significant incidents causing harm to Mr Y which with 1:1 care could have been prevented;
- Obtain evidence from the GP surgery, from the Lead Tissue Viability Nurse;
- Establish when Mr Y received his injury, what action the staff at the care home took, and decide if they took suitable action and whether an ambulance should have been called on 24 December 2013;
- Consider if the procedure for requesting 1:1 funding could be improved.

19. This first safeguarding investigation reported on 1 October 2014. Dr X complained it had not covered all the concerns raised and so the Council commissioned a review of the investigation. The reviewer decided the investigation had not properly considered all concerns and recommended a second investigation.

20. Having considered its reviewer's advice the Council's officers met with Dr X in May 2015 to discuss the terms of reference for a second safeguarding investigation. This would cover those concerns not covered in the first investigation. The Council agreed terms of reference on 10 June 2015 (see paragraph 10 above). They include whether "[Mr Y's] fall on 24 December 2013, or some other occurrence that caused [Mr Y] harm would not have happened had [Mr Y] received 1:1 supervision"

Second Safeguarding Investigation.

21. This investigation had to decide whether, had Mr Y had received 1:1 care as he should during July to December 2013, his fall or some other occurrence that caused him harm would not have happened.

22. The Chair decided the investigation could not know as a matter of fact whether Mr Y's fall would have been prevented. The Chair decided the evidence was inconclusive.

What the safeguarding investigations found

23. The investigations noted staff said Mr Y often refused personal care presenting difficulties for staff. However, the investigator said that: "...if one to one care had been provided [Mr Y] may have built relationships with carers which may have helped when providing personal care..."

24. In brief the investigations found:

- The care provider failed to issue a care plan showing what 1:1 care should be given and did not give details of how it should be delivered. For example it did not say if Mr Y needed someone in his room all the time or just hourly observations to check he did not need help;
- The reasons for the 1:1 were both to manage Mr Y's night-time agitations within his room as well as preventing him wandering and to manage his risk of falls;
- The care home failed to tell both Dr X and the care funding authority about the change from 1:1 night-time care;
- Records did not show any falls at night between July 2013 until the fall on 24 December 2013;

- The records show no risk assessments undertaken when planning to stop the 1:1 care or after that care had stopped or any review of that decision.

25. The investigation found fault in the patchy records kept by the care home. Those records show Mr Y had 14 falls between 10 November 2012 and 24 December 2013. Four of those falls had been at night (three before 1:1 care had been put in place). However, the records show no night-time falls between July 2013 and Mr Y's fall on 24 December 2013.

26. The investigation found no daytime 1:1 care in place despite the care home saying it had switched it from night time to day time. It found no evidence of what had caused Mr Y to fall on 24 December 2013.

Evidential Test applied by the Chair of the Second Safeguarding Investigation

27. The Council says it undertakes all safeguarding investigations using the civil law evidential test of 'balance of probabilities'. In other words on the evidence it is likely something did or did not happen. Reference to that test is set out in its Safeguarding Procedure. It refutes the suggestion the terms of reference prevented the Chair from reaching a decision that the allegations were substantiated. The Chair as an experienced person would know what test to apply.

28. Dr X says it may not be possible to know as a fact whether the fall could have been prevented. However in his view on the balance of probabilities the failure to have in place 1:1 supervision means it is more likely to happen. He says with 1:1 supervision Mr Y would have someone with him most of the time and that is likely to have prevented most if not all falls. Dr X says the terms of reference prevented the Chair of the Safeguarding Investigation from being able to reach an appropriate decision. Dr X says the appropriate decision would be to uphold the allegations as Substantiated.

Complaint about the Terms of Reference

29. In November 2015 Dr X complained to the Council about the reasoning for the findings made in the second investigation report. Dr X complained the Council had set the terms of reference too narrowly. This left the Safeguarding Chair with no choice but to find the complaint about the impact of the lack of 1:1 care inconclusive. In Dr X's view had the Council properly set the terms the Chair could decide partially or wholly substantiated, or not substantiated.

30. The Council appointed the same reviewer who had reviewed its first safeguarding investigation to review the second. The reviewer upheld six of the complaints and dismissed nine. The six complaints upheld are:

- The investigation had only considered whether the care home had followed its own policies and procedures not whether those procedures were satisfactory;
- The investigation gave inadequate weight to the care home's failure to properly carry out all the strategies and steps set out in its policies and procedures;
- The investigation unreasonable accepted the care home's assertion that a resident assigned to be within high visibility meant the same as regular monitoring;
- The finding of the investigation that the care home did all it could have done to prevent Mr Y falling does not match the available evidence;

- The investigation wrongly found the entirety of the care home's risk assessment and falls management including that arising from 1:1 provision should not have been considered together when it should.

Reviewer's comments on the terms of reference and recommendations

31. The reviewer did not uphold the complaint about the Safeguarding Chair's decision about whether Mr Y's fall could have been prevented. The Safeguarding Chair said the evidence was inconclusive on the question but for the lack of 1:1 care Mr Y's fall or some other harm "would not have happened".

32. However, the reviewer criticised the terms of reference. She says the Safeguarding Chair had to consider whether Mr Y's fall or some other harm "would not have happened" rather than "would probably not have happened" or "might not have happened". The reviewer agrees with the Safeguarding Chair that on the evidence it simply was not possible to come to such a definite conclusion as required by the words "would not".

33. In the reviewer's view the test set by the terms of reference came closer to the criminal test of 'beyond reasonable doubt'. And not the 'balance of probabilities', test set by the Safeguarding Procedures. So while the reviewer decided the safeguarding investigation had properly applied the terms of reference, those terms of reference precluded the safeguarding chair from applying the right evidential test.

34. The reviewer recommended in future the Council draft terms of reference more closely in line with the Safeguarding Policy to avoid setting the test for evidence too high. She also recommended harmonising the Council's Procedure with the SAR Guidance.

35. On 15 March 2016 the Council wrote to Dr X saying:

"I fully accept the findings and recommendations of the report and would like to offer my sincere and unreserved apologies for the inadequacies of the safeguarding process and conclusions as identified by [the Council's Reviewer]."

36. The letter then promised the Council would revisit and revise the Safeguarding Investigation Outcomes letter.

Review of outcomes of Second Safeguarding Investigation

37. In keeping with that promise the Council's Head of Safeguarding wrote to Dr X on 29 April 2016 with a revised outcomes letter. The Head of Safeguarding not the Chair of the Safeguarding Investigation reviewed the Outcomes letter. The Council says:

"In reconsidering the conclusions letter I have kept to the Terms of Reference that were agreed by all parties."

38. It did not change the result on the question whether Mr Y's fall would not have happened: that remained inconclusive.

View of the Safeguarding Chair

39. In response to my draft decision the Safeguarding Chair gave a statement explaining the burden of proof she applied. The Safeguarding Chair has several academic qualifications in social work, over 25 years experience including training staff in the Care Act framework. She is a member of the Local Government Association's peer review team and experienced in serious case reviews and safeguarding adult boards.

40. The Safeguarding Chair says she always applies the civil evidential test when deciding safeguarding investigations. She explained she considered all the evidence including discussions in the safeguarding meetings, and the information in the safeguarding investigation report. Her decision applying the test 'would probably not have happened' was inconclusive because she says it was not possible to know if the provision of 1:1 care probably would have prevented the fall in December 2013. The Safeguarding Chair did not feel constrained by the terms of reference because she always uses the probability test and knows that is the correct test for safeguarding investigations. On that test the evidence she says led her to an inconclusive finding. Such a finding is one of the five permitted conclusions.

Safeguarding planning meetings

41. The planning meetings discussed issues raised by Dr X and professionals. They discussed the reasons for commissioning 1:1 care, the lack of any consultation on its removal and the absence of any records of proper risk assessments undertaken by staff. The meetings noted the care home reviewed the care plan but did not update it. Therefore it had not properly recorded the reasons for any change or when those changes would be reviewed and how they had been discussed with Mr Y or Dr X. The care plan gave no information about why the care home failed to provide daytime 1:1 care but continued to accept funding from the funding authority for that care.

42. At the meeting on 28 September and the final meeting in October 2015 Dr X presented his written views on the draft report on safeguarding. The Chair considered Dr X's views before issuing the report on 12 October 2015.

Analysis – is there fault resulting in injustice?

43. It is not my role to say whether the failure to provide 1:1 care to Mr Y caused him to fall. It is to consider whether the Council investigated the concerns without fault.

44. It is for the safeguarding investigation to decide on the evidence before it whether the allegations are substantiated. And to decide what recommendations to make to resolve poor care and prevent repetition. The safeguarding investigations found fault and made recommendations for improvements.

45. The safeguarding planning meetings enabled all parties to present information and raise concerns. What weight is given to that information is a matter for the decision maker. I am satisfied the meetings enabled everyone to put forward their views and present information. I cannot comment on the weight given to any part of that evidence.

46. The Council had to commission a review of both safeguarding investigations. And in both the reviewer found faults and recommended changes. Therefore I find fault in the Council's handling of both safeguarding investigations.

47. The reviewer found the Safeguarding Chair made a decision within the constraints of the terms of reference for the second safeguarding investigation. However, the reviewer found the terms of reference failed to reflect the proper evidential test. The terms of reference should not constrain the Safeguarding Chair from deciding a case on the balance of probabilities.

48. The reviewer says using the words "would not have happened" asks for a higher test than "probably would not have happened". The Council says the Safeguarding Chair would know as an experienced person in the field that all

decisions should be made applying the balance of probabilities test. It is set out in the Safeguarding Procedure. Even so when drafting its terms of reference it should not set the bar so high that this could be in doubt.

49. The Council told Dr X in its letter of 15 March 2016 it accepted the findings and recommendations of the reviewer. It did not qualify that statement by disagreeing with the reviewer's comments and recommendations about the terms of reference. Therefore it had accepted the criticism the reviewer makes. But it failed to apply that to its review of the Outcomes Letter. It kept the terms of reference the reviewer had criticised. The Council believes it did not act with fault because the reviewer's recommendations said 'in future' it should draft terms of reference more closely reflecting the Safeguarding Policy. I find that it acted with fault in not at least reflecting in the revised outcomes letter the comments about the problems with the terms of reference.

50. It acted with fault in setting the terms of reference and I agree with the reviewer those terms should follow the safeguarding policy more closely to avoid any doubt.

51. Dr X lost confidence in the probity of the investigations because of the faults identified by the reviewer. He believes the terms of reference prevented the Chair from upholding his complaint and he wants that reviewed.

52. Both safeguarding investigations were found wanting by the reviewer. I have to decide if those faults led to a different decision than the Chair would have made but for those faults. The Chair's statement is helpful on this point. Drawing on her knowledge and many years experience of safeguarding and the evidential test needed to support a decision, the Chair says she applied the 'balance of probability' test. The strictly drawn terms of reference did not constrain the Chair from exercising that test but did put the question very clearly on whether Mr Y would have fallen if 1:1 care had been in place. In her view she could not say he probably would or would not have fallen hence she recorded an inconclusive decision. It is for the decision maker to decide on the weight of the evidence whether she can decide something as substantially, partially or inconclusively proven subject to the right evidential test. I find the Safeguarding Chair applied the correct evidential test having considered all relevant information before her. The strictly worded terms of reference created doubt which they should not. Even on the less strict test of 'probability' a decision maker may still find they cannot reach anything but an inconclusive view.

53. Dr X's loss of confidence given that both safeguarding investigations resulted in criticisms on review means he may not have confidence in what the Safeguarding Chair says now. I understand that. However, it is clear to me that in drawing on her professional expertise and experience and exercising her professional judgement the Safeguarding Chair applied the correct test to the evidence collected. But for the faults in the process I cannot say a different decision would have been made.

54. Dr X asked the Council to remedy his complaint by reviewing the question using the correct evidential test. That may have restored his confidence in the Council's decisions but it could not guarantee the decision he hoped for. I put this to the Council and suggested a peer review may help. However, it declined to put this to a further review. The Safeguarding Chair's statement expressing her clear understanding of the evidential test to be applied means I cannot challenge the merits of her decision or recommend a further review.

Recommended and agreed action

55. To remedy the injustice arising from the faults identified I recommend and the Council agrees to:

- Apologise to Dr X for inconvenience time and distress to which he has been put;
- Pay to Dr X £500 for the time and inconvenience caused by the faulty safeguarding investigations.

Final decision

56. The Council failed to conduct two safeguarding investigations without fault and failed to set out clear terms of reference resulting in a loss of confidence in the decisions and avoidable inconvenience and anxiety.

Investigator's decision on behalf of the Ombudsman

30 March 2017

Complaint reference:
16 013 395

Complaint against:
Bath and North East Somerset Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: The Council's delivery partner and its contractor delayed in providing Mr B with a quote for replacement doors. As a result he may have lost out on grant funding.

The complaint

1. The complainant, whom I will call Mr B, complains that, because of the failure of a delivery partner, he has been disadvantaged in the Council's Energy at Home scheme which would have provided a larger grant for replacement doors (alongside cavity wall insulation) if it had been completed in 2015/16. The grant available with the current delivery partner is less and the Council has refused to match the former grant level.

The Ombudsman's role and powers

2. The Ombudsman investigates complaints about 'maladministration' and 'service failure'. In this statement, I have used the word fault to refer to these. If the Ombudsman is satisfied with a council's actions or proposed actions, she can complete her investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i))***

How I considered this complaint

3. I have considered all the information provided by Mr B together with information provided by the Council.
4. I sent my draft decision to Mr B and the Council and considered their comments.

What I found

5. In December 2015 Mr B enquired about funding for cavity wall insulation and replacing his porch doors under the Council's Energy at Home scheme.
6. Under the scheme, the Council helps people install energy-saving home improvements such as insulation, energy efficient glazing and external doors or heating system upgrades. It also helps them access grants and find an installer to carry out the work.
7. Mr B was referred to Company X for an assessor to visit his property and prepare an energy assessment report.
8. Mr B says the assessor told him he would qualify for funding towards cavity wall insulation with a £200 contribution from himself, and a £1000 grant towards the cost of replacing his porch doors.

9. On 8 February 2016 Company X followed its normal process of sending out a request to quote to two sub-contractors. They did not reply which meant the next stage in the process (Company X contacting the customer) was not triggered.

10. On 15 March 2016 Mr B telephoned Company X and it chased up the contractors.

11. On 16 March 2016 one of the contractors said it could not provide a quote for the porch doors. Company X explained to the other contractor that it would ideally like all quotes accepted by 21 March 2016.

12. On 22 March 2016 the contractors gave Mr B a quote for the cavity wall insulation and a two panel sliding porch door. They explained they could not find a supplier to provide a four panel sliding door which Mr B needed. Company X recorded in its notes that Mr B would get back to them regarding the quote.

13. Mr B spoke to Company X again on 29 March 2016 to discuss the quotes and the possibility of using the funding to replace his front door instead of the porch doors. He could not accept a quote for the two panel sliding door as this would leave a very narrow entry and exit. Company X told him it was no longer possible to access the grant before the end of March deadline.

14. Mr B made further enquiries about pursuing the scheme in September 2016. The Council explained that, although the scheme was still running, Company X was no longer the delivery partner. With regard to the cavity wall insulation, the current grant terms were different to those previously available but the Council agreed to match any shortfall so Mr B would not pay any more than he would have done under the previous scheme. However, there is no grant currently available for the cost of installing doors. Mr B considers the Council should fund the installation of a new front door as he has missed out on grant funding for this. The Council has declined. It did however agree to add him to a waiting list in case funding becomes available in future.

Analysis

15. If Mr B had received a grant in 2015/16, he would have paid £200 towards cavity wall insulation and received £1000 grant funding towards a front door or porch.

16. The information pack given to Mr B at the outset explains the procedure for the Energy at Home scheme as follows:

- At stage 1 the Energy at Home Advice Service helps applicants with information, advice and guidance on the energy-saving home improvements they might want to make together with details about the Energy at Home scheme and what grants and finance options are available;
- At stage 2 the Advice Service refers the applicant to Company X who makes an appointment for an assessor to visit. The assessor then sends the applicant a home energy assessment report;
- At stage 3, if the applicant has decided which measures he wants to install, he can contact Company X to arrange a quote. Company X provides the applicant with a quote for the works including the full cost of the works, the amount of grant the applicant is eligible for and the amount he needs to pay himself;
- At stage 4, if the applicant decides to proceed, he receives a form and grant guidance notes. He must complete and return the form if he wants to use the Home Energy Top up Grant. The form provides details of ownership of the property and any planning requirements;
- At stage 5 the applicant should contact Company X to arrange the installation.

17. Mr B only got as far as stage 3 of the process. He received a quote from Company X. But, when he spoke to them on 29 March 2016, it was too late for him to obtain an alternative quote for a front door instead of porch doors then complete the grant application and have this approved before the grant deadline.

18. Mr B says the delay was caused by the contractors who did not provide a quote until 22 March 2016 despite this being requested on 8 February 2016. In addition, when the contractors did provide a quote he says it was unworkable because it was for a two panel door rather than a four panel door.

19. The Council says the delay in providing the quote appears to stem from the combination of a request for an unusual measure (four panel door) and the high volume of work that Company X was dealing with at the time. It says Company X was under considerable pressure because of the number of people referred into the scheme and the fact that the grant deadline was approaching.

20. I find the contractors were not at fault in providing a quote for a two panel door. They explained they could not find a supplier for a four panel door and therefore gave this quote as an alternative. The other contractors were also unable to provide a quote for a four panel door. However, I find the contractors' delay in providing a quote was fault.

21. I accept Company X chased up the quote as soon as Mr B telephoned but it should have done so sooner. I appreciate Company X was under a great deal of pressure at the time but this does not alter the fact that it was at fault in failing to chase up the quote.

Injustice

22. Mr B says he lost out on a £1000 grant towards a new front door which he would have accepted as an alternative to porch doors.

23. Even if the contractors had quoted sooner, I cannot say for certain that Mr B would have completed all the necessary steps before the deadline. He would have had to refuse the quote and request an alternative quote for a front door, receive and accept the alternative quote, complete a grant application form and return it to the Council who would then decide whether or not the grant should be approved.

24. There was no obligation on the Council to provide funding until Mr B had accepted a quote and obtained a grant. I cannot therefore conclude he definitely lost out on the £1000 grant as a result of the delay in obtaining the quote. However, he will always have the uncertainty of not knowing whether, but for the fault, the outcome could have been different.

25. Mr B says Company X told him a visit from the contractor would guarantee the grant funding. The Council says Company X does not know why he was under this impression as this is not the normal process. Clearly, a contractor's visit would not secure grant funding as Mr B would have had to apply to the Council for a grant and have this approved. However, there is clearly a conflict of evidence about who said what to whom. In the absence of tangible evidence to support one version of events over the other, I cannot reach a conclusion on this point.

26. Mr B says he was told there was no time limit for obtaining a grant. In the absence of tangible evidence to prove exactly what was said, I cannot reach a conclusion on this point. However, Company X's notes of a telephone conversation with the contractors on 16 March 2016 states, "we would ideally like

all quotes to be accepted by the 21st". This suggests Company X was aware of the end of March deadline.

Agreed action

27. The Council has agreed to pay Mr B £250 in recognition of his uncertainty about whether, but for the faults identified, the outcome could have been different.

Final decision

28. I uphold Mr B's complaint. The Council's delivery partner and its contractor were at fault in failing to ensure he received a quote within a reasonable time.

29. The Council has provided a satisfactory remedy for the injustice suffered by Mr B so I have completed my investigation.

Investigator's decision on behalf of the Ombudsman

20 March 2017

Complaint reference:
16 007 850

Complaint against:
Bath and North East Somerset Council

Local Government
OMBUDSMAN

The Ombudsman's final decision

Summary: The Council was at fault in the way it conducted a safeguarding investigation. The Council has agreed to a remedy to acknowledge the impact of this fault.

The complaint

1. A care provider, which I shall refer to as CP, complains about the way the Council conducted a safeguarding investigation about a deceased resident in a nursing home it owned.

2. In particular CP complains the Council:

   a) had no legal authority to reopen the safeguarding investigation;

   b) did not conduct the second safeguarding investigation properly;

   c) did not take into account the representations it made that the second report was biased; and

   d) did not deal with its complaint properly.

3. CP claims to have suffered damage to its reputation and consequential financial losses.

The Ombudsman's role and powers

4. We investigate complaints of injustice caused by maladministration and service failure. I have used the word fault to refer to these. We cannot question whether a council's decision is right or wrong simply because the complainant disagrees with it. We must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, section 34(3), as amended)***

5. We must also consider whether any fault has had an adverse impact on the person making the complaint. I 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)***

How I considered this complaint

6. I read the papers submitted by CP and spoke to its Compliance Manager, Mr P, over the telephone. I also considered the Council's comments about the complaint and the supporting documents it provided. I sent a draft version of this statement to both parties and have taken into account the comments received by the Council in response.

What I found

Policy background

7. At the time of the events complained of the relevant safeguarding guidance was, "No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse"

8. The statutory guidance says an adult protection investigation should find out facts, and assess the needs of the vulnerable adult for protection, support and redress. It should also decide what follow up action should be taken.

9. In this context the "No Secrets" guidance stipulates the importance of ensuring that robust local safeguarding procedures are in place to facilitate effective joint working and sharing of information.

10. The Council had a multi-agency policy and procedure in place that reflected these principles. The purpose of the Council's policy was to "set out how all individuals and agencies with responsibility for the well being and protection of adults at risk should work together to safeguard them from abuse, exploitation and/or mistreatment.

11. The Council also had a comprehensive multi agency procedure in place that it followed when dealing with the safeguarding investigation that is the subject of this complaint.

The facts

12. Home Z is a nursing home owned by CP, a limited company. This complaint has been brought on behalf of CP by its Compliance Manager, Mr P.

13. Mr D was a resident at Home Z. He was 85 when he moved there in October 2012. Mr D had dementia and was blind. He had a number of other conditions including insomnia, lymphodema, impaired hearing and psychosis.

14. Mr D's placement at Home Z was funded by the NHS because his health care needs were so complex.

15. Mr D often demonstrated challenging behaviour which staff at Home Z found difficult to manage within their existing staff ratios. Mr D's insomnia and dementia meant he would often wander into other residents' rooms at night. From February 2013, the NHS gave Home Z extra funding to provide Mr D with 1:1 support during the night.

16. This support was stopped by the manager of Home Z in July 2013. He did not tell anyone else at Home Z or Mr D's son, whom I shall refer to as Mr E. The circumstances of this and the repercussions were a key factor in the subsequent safeguarding investigations. There was also uncertainty about the purpose of the 1:1 support and the level and time it was provided to Mr D at various times he was there.

17. On 24 December 2013, Mr D fell whilst alone in his room at night and was admitted to hospital the following day. He passed away in hospital on 3 January 2014. The primary cause of death was subsequently recorded by HM Coroner as pneumonia.

18. On 7 January 2014, the Council received a safeguarding referral from the Care Quality Commission ("CQC"). Mr E had complained to the CQC about the circumstances leading up to his father's death and CQC had referred this on to the Council as the lead agency with responsibility for safeguarding. Mr E's initial complaint was about the lack of 1:1 support on 24 December 2013. He said the

fall would not have happened if the 1:1 support had been in place. He also said the home was negligent in the way it dealt with his father once he was found in his room that night. He also raised other concerns about the quality of care received by his father while at the home which he said was neglect.

19. The Council started a safeguarding investigation in accordance with its procedures. A report was produced on 1 October 2014. This report concluded no 1:1 support was being provided at the time of the fall on 24 December 2013. However, it could not conclude that significant harm occurred as a result of this. The report also found there was "no neglect in resulting in significant harm" arising from the care Mr D received at Home Z.

20. Mr E was not satisfied with the report or its outcome and recommendations. He submitted a complaint to the Council. He maintained his view that if his father had been in receipt of 1:1 support, this would have prevented him from falling on 24 December 2013.

21. In response to this complaint, the Council asked an independent person, whom I shall refer to as Ms B, to undertake a review of the report. In March 2015, Ms B recommended the safeguarding investigation should be reopened because the original report had not focussed enough on the fall and whether it could reasonably have been prevented.

22. On 21 May 2015, the Council's Head of Safeguarding met with Mr E to discuss what the terms of reference for the second investigation should be. A multi agency meeting was convened on 2 June 2014 to request the further involvement of the various agencies and discuss the terms of reference. Ms G, the Operations Director employed by CP, attended this meeting.

23. The agreed terms of reference were:

"*The investigation will review and analyse whether the allegation of neglect could be substantiated if the following were identified:*

a) *The falls risk assessment and/or consequent falls prevention strategies were inadequate; and/or*

b) *Mr D continued to require 1:1 supervision; whether for his falls risk or some other reason; and/or*

c) *The fall on 24 December 2013, or some other occurrence that caused Mr D harm would not have happened had Mr D received 1:1 supervision".*

24. On 6 August 2015, the Council circulated a draft version of the second investigation report to all parties including Mr E and Ms G. CP says the Council also sent it to HM Coroner which it should not have done. CP was dissatisfied with the outcome of the second investigation. On 2 September 2015, Ms G sent the Council a list of factual inaccuracies and requested the report be amended.

25. Five safeguarding adults planning meetings were held on 10 August, 11, 15 and 29 September and 8 October 2015. The purpose of these meetings was to "consider the responses/factual inaccuracies report from CP and make changes where agreed by those present". I have seen the transcribed notes from these meetings. Both Mrs G and Mr E were present along with representatives from other agencies and the author of the report. Detailed discussions took place and Ms G's views on the draft report were discussed in great detail and a number of changes made to reflect these.

26. The main issues raised by CP and discussed at the meetings were:

- Staffing ratios
- Relevance and recording of sleeping patterns
- The link between 1:1 support with changes in behavior
- How the fall was documented by care staff
- Issues around medication – both recording and the possible effect on Mr D's behaviour
- Recording practices of falls at the home
- Circumstances of the removal of the 1:1 support
- Relevance of Mr D being locked in his room on a particular occasion
- Fraud aspects of the case

27. The investigator produced her final report on 12 October 2015. The overall conclusion was that the allegation was partially substantiated. In relation to the terms of reference the findings are set out below (with my commentary on the conclusions added in bold):

"*The investigation will review and analyse whether the allegation of neglect could be substantiated if the following were identified:*

a) *The falls risk assessment* ***(Substantiated)*** *and/or consequent falls prevention strategies were inadequate* ***(Unsubstantiated – this was later changed to Substantiated)****; and/or*

b) *Mr D continued to require 1:1 supervision; whether for his falls risk or some other reason* ***(Substantiated)****; and/or*

c) *The fall on 24 December 2013, or some other occurrence that caused Mr D harm would not have happened had Mr D received 1:1 supervision* ***(Inconclusive)****".*

28. I accept CP's view that the outcome of the second investigation was less favourable to CP than the first one had been.

29. CP wrote a formal letter of complaint to the Council on 1 December 2015. The complaint was founded on two key issues:

"1. The investigation unnecessarily deviated from the scope of the terms of reference whilst excluding important factors of focus. The evidence gathered has not been properly evaluated.

2. The key points we raised repeatedly were not listened to or included in the final report and the subsequent determination. As a result allegations outlined in the terms of reference have not been considered in a consistent or logical method to reach a fair outcome"

30. The complaint highlighted many areas of concern. CP invited the Council to change all of the outcomes to "Not substantiated"

31. The Council responded, in accordance with Stage 1 of its complaints procedure on 29 April 2016, but did not amend the overall recommendations in favour of CP.

32. The Council attached to its response an amended outcome letter, to replace the one sent in October 2015. This letter told CP the Council had received a complaint about the outcome of the second investigation from Mr E as well as CP. In response, the Council had commissioned Ms B (who had previously been involved when she reviewed the first safeguarding investigation following Mr E's

complaint) to consider Mr E's complaint. The Council's Head of Safeguarding had considered CP's complaint.

33. The Head of Safeguarding said she had taken into account both her own enquiries and the Independent Complaint investigators report when re-issuing the outcome letter. This letter provided more detailed explanation about each of the individual findings. One of the outcomes had also changed. One of the allegations was changed from "not substantiated" to "substantiated".

34. Again, I accept CP's view that this revision was not in favour of CP.

35. On 14 July 2016, CP sent a further formal complaint to the Council. This detailed letter claimed "the draft report and subsequent final report were contrived for purely political purposes; the resulting investigation activities sought only to justify a predetermined outcome and not consider relevant information and formulate an objective evaluation. We believe the intention was to appease and to avoid further complaint from Mr E and to provide him with grounds for harm or litigation against the company".

36. CP also expressed dissatisfaction with Ms B's involvement in the matter. She was commissioned by the Council to carry out the review of the first safeguarding investigation as well as responding to Mr E's complaint about the outcome of the second investigation. CP was asked to comment on the propriety of this.

37. Included in the letter were 12 questions CP wanted the Council to answer: CP was effectively asking the Council to conduct a full review of all matters raised since June 2015. CP also requested that the Council should ensure "that a suitably clinically qualified professional is involved or consulted in the consideration of our complaint".

38. The Council responded on 4 August 2016. It explained that, "the aim of the Stage 2 review is to ensure that all matters raised in the original complaint have been comprehensively and accurately addressed." The Council concluded that nothing further could be added to the response provided on 29 April 2016. CP then complained to the Ombudsman.

39. Meanwhile, in June 2016, HM Coroner, following an inquest into the death of Mr D, recorded the cause of death as "accidental". CP says that this was brought to the attention of the press and CP has been exposed to negative press coverage which has had an impact on its reputation as well as financial losses.

Was there fault leading to injustice?

40. The purpose of my investigation is to ascertain, based on evidence, whether there has been any fault by the Council in the way it reopened and conducted the safeguarding investigation and the way in which it reached its decision. If so I then have to consider whether the complainant has suffered an injustice as a result.

The Council was not entitled to reopen the safeguarding investigation

41. There is no specific guidance, either within the national guidance or Council policy, about if and when safeguarding investigations can be reopened. But as the main purpose of such an investigation is to prevent future harm I would expect a Council, if new evidence is presented, to be able to look into it further. Indeed the Ombudsman may have found fault if the Council had not commissioned the second report.

42. I do not agree with CP that a "double jeopardy" situation arose. The second investigation focused on areas not covered by the first report. The second

investigation was restricted to areas specifically identified in terms of reference upon which CP was invited to comment. I have not found evidence of any complaint from the home about these terms of reference, other than the involvement of Mr E in their drafting.

The investigation was conducted in such a way as to give the impression of bias and the outcome was pre-determined

43. I have seen no evidence of bias or that the outcome was pre-determined. CP was consulted when the terms of reference were set for the second investigation. I have seen evidence that all of CP's many representations and concerns were taken into consideration. The second report was shared with CP whilst it was at its draft stage and several meetings took place where CP was provided with the opportunity to set out every one of these in some considerable detail. There were clearly some differences of opinion about what was relevant but the investigator was entitled to form her own view. CP does not agree with the outcomes but I do not find fault in the way they were reached.

44. It is clear Mr E was adamant the fall that took place on 24 December was preventable and it is clear that he is keen for the responsible agencies to be held to account. It is also clear that some of his complaints have made the Council take steps that they would not have done otherwise, such as commissioning Ms B to review the first safeguarding investigation and changing one of the outcomes from the second investigation from "unsubstantiated" to "substantiated". However, this does not mean there is bias and I have not seen evidence of this. Mr E presented the Council with information and the Council was duty bound to consider it.

45. Whilst there is no evidence of bias, the very fact the safeguarding investigation was reopened and the outcomes from the second investigation had to be changed is evidence the Council did not conduct the process properly. This is fault.

46. CP is not happy that as part of the second investigation the investigator did not interview particular members of staff at Home Z. This was a professional decision for the investigator to make and this is not one I can question. I do not consider the decision was irrational.

47. CP has also expressed concern about the involvement of Ms B. The Council has told me that she is a solicitor, entirely independent of the Council and was asked to review complaint from Mr E about the second safeguarding because she already had the in depth knowledge of the case from when she reviewed the first investigation. I consider this to be a reasonable position and do not criticise the Council for this.

48. Similarly, I have found no evidence of a pre-determined outcome. Quite the opposite. The Council has responded to representations from all sides, including many put forward by CP, and has gone to great lengths to ensure all parties have had their say and their concerns and arguments taken into consideration.

The outcome from the second investigation did not take into account CP's representations that it was biased

49. CP claims the investigation was biased in favour of Mr E and the outcome that he wanted to achieve. Mr P has told me Mr E wanted the outcome of the safeguarding investigation to be critical of Home Z. I cannot comment on this but I have seen evidence that Mr E thought the fall which he believes directly contributed to his father's death was preventable.

50. CP says the Council was unduly influenced by Mr E. In support of this CP says the Council only reopened the safeguarding investigation to appease Mr E. It also claims he was too involved with the process generally, including being involved with drafting the terms of reference for the second investigation and being able to attend the post review meetings where the draft report was discussed.

51. The Council was not prohibited either in law or by its own procedures to involve Mr E as much as it did during the process. One of the guiding principles that underpins safeguarding is to involve the person who has suffered harm as much as possible and practicable. As Mr D himself was no longer alive, the Council effectively accepted Mr E to speak for his father. I therefore do not criticise the Council for involving Mr E as it did.

The Council's complaints process was unfair and exposed the company to serious loss of reputation

52. I have found no evidence that the Council did not thoroughly look into CP's complaint.

53. I note the Stage 2 response did not address each and every point that CP had asked it to, but the Council had reached a point where it felt nothing further could be gained from investigating matters again. I do not criticise the Council for this.

54. Following the inquest, CP was the subject of negative press coverage but this is not attributable to the Council's actions in the way it conducted the safeguarding investigations.

My overall finding

55. However, I cannot ignore the fact both safeguarding investigations were reviewed by independent persons who identified problems with the process and the outcome. Whilst the Council acted properly in rectifying these issues, they should not have happened in the first place. This is fault. I consider CP has suffered an injustice from this because of the time and trouble involved in the second investigation.

Conclusion

56. I am satisfied the Council carried out its responsibility to conduct a thorough investigation into the circumstances that led to the death of Mr D. This was the primary purpose of the exercise. The independent investigator appointed by the Council has demonstrated to my satisfaction that she listened to the representations made by all parties, including CP and Mr E and came to her own decision and conclusions. It is not my role to conduct a further investigation into the circumstances into the death of Mr D.

57. However, there were failings in the process and it was unnecessarily lengthy and this was due to fault by the Council.

Agreed action

58. The Council has agreed to apologise to CP for the length of time it took to complete the safeguarding investigation. The Council has also agreed to pay CP £500 to acknowledge the impact of the fault, particularly the time and trouble spent attending meetings during the second safeguarding investigation

Final decision

59. The Council was at fault in the way it conducted a safeguarding investigation.

Investigator's decision on behalf of the Ombudsman