Local Government & Social Care OMBUDSMAN

Unprecedented pressure:

Learning from complaints about council and care provider actions during the COVID-19 pandemic

February 2021

Contents

Ombudsman's Foreword

The COVID-19 pandemic has created unprecedented pressures for local authorities and care providers, requiring them to re-prioritise and re-design existing services whilst at the same time adopting new duties to support residents and local businesses through a time of national crisis. Local government was required to do all of this at a rapid pace, in a continuously changing environment of uncertainty and risk. This report looks at how councils and care services coped with those challenges, viewed through the lens of public complaints.

It follows a similar structure to "Under Pressure" – the report we published just over three years ago showing what our investigations revealed about how councils dealt with another challenge: a decade of cuts.

For many of us, the pandemic will conjure images of anxiety and loss – perhaps through direct experiences, but certainly through moving stories shared by others. This report inevitably touches upon some of those personal tragedies.

For example, a woman who contracted and died from COVID-19, while at a care home with faltering infection control procedures that significantly increased her risk – and who later tried to cover up the facts. Or, the homeless family left to sofa surf then sleep in a tent at the height of the pandemic, after falling through the cracks between different departments of the same council.

However, the purpose of our work is not to investigate the pandemic itself, nor are we generally best placed to look at some of the most sensitive personal concerns about matters such as avoidable deaths. Our primary focus is on systems and services, and that focus is the subject of this report.

The main insight from the first 18 months of our investigations, is that COVID-19 exposed fault-lines in council and care provider systems that were already present. It heaped additional pressure on pre-existing weaknesses – some of the same weaknesses we highlighted in our previous Under Pressure report.

And amongst those services that showed the strain during the pandemic, I am particularly concerned that, in some authorities, dealing with public concerns and complaints was itself a casualty of the crisis. At a time when listening to public problems was more important than ever, we saw some overstretched and under-resourced Complaints Teams struggle to cope. If evidence was needed, this report proves that managing complaints should be considered a frontline service.

> ***I am particularly concerned that, in some authorities, dealing with public concerns and complaints was itself a casualty of the crisis.***

However, while acknowledging the challenges, there is much in this report that local authorities and social care providers can be proud of. There is no indication, from our investigations, of systemic failure or collapse in local services under the pressures of the pandemic. On the contrary, the proportion of complaints we upheld where COVID-19 was a factor was lower than complaints where it wasn't, over the same period.

It is also worth noting what is absent from this report. Despite the exceptional context, we did not uncover a host of new types of faults arising from the pandemic. For example, we received remarkably few complaints about the new, and potentially controversial, duties that councils were given during the pandemic, such as those to promote social distancing and the use of 'COVID Marshals'. And in fundamental services, such as local government licensing, we received surprisingly few complaints – in contrast to media reports about substantial problems with some national administrative systems.

So, whilst in no way diminishing the sometimes tragic individual cases we investigated about deaths in care or poor end of life support, the evidence from public complaints as a whole suggests that the local government and adult care sectors pulled together under stress to maintain their services as far as could be reasonably expected in very difficult circumstances.

The one significant area of new and unexpected casework deriving from COVID-19 has come from business owners complaining about the decisions councils made on their applications for grants to support the impact of lockdowns and restrictions. Around 40% of our COVID investigations have been about this topic.

We recognise councils were setting up schemes quickly and with the flexibility to tailor them to local needs. And we also recognise the need for adequate safeguards to prevent misuse. However, we did find some common faults in this area. We saw some examples of blanket policy decisions overriding individual circumstances and an absence of ways for people to appeal or review their cases. Yet, even in this area, we did not find fault in the majority of cases we investigated.

In presenting these findings, we readily acknowledge that we only ever see part of the picture. People only come to us when they believe something is wrong, and possibly during the pandemic the desire to pursue complaints linked to COVID-19 was tempered by reduced expectations.

There will be other routes to examine the wider connections between the pandemic, public policy, and public service delivery. However I hope that, added to evidence from others, the insight from people's direct experiences in our complaints, can add colour to the picture of how local services responded during the pandemic. This body of work, including some 90 case studies, is offered as an important resource for serious case reviews, public inquiries, and inquests.

> ***The local government and the adult care sectors pulled together under stress to maintain their services as far as could be expected in very difficult circumstances.***

We have consciously chosen here to focus on the administrative actions of councils and care providers, with our usual emphasis on how we can learn from what went wrong. As such, this report particularly highlights the recommendations that so many organisations have already adopted in response to our investigations to make improvements to their services to avoid repeating similar faults.

On that front, I welcome that many councils and care providers took the right approach to our decisions. Many have agreed to incorporate our findings into their own reviews of processes and practices in the light of the crisis. I hope this report will provide further stimulation for all councils and care providers to reflect on the lessons learned from working during these intense conditions and how complaints can help lead to sustained improvement.

Michael King,

Local Government and Social Care Ombudsman

About this report

In May 2020 we issued a short guide to councils and care providers, which set out our approach to considering complaints about delivering services during COVID-19.

It was an addendum to our existing principles of good administrative practice, and intended to encourage organisations to reflect on practice during the crisis. It has six principles of good practice

This report pulls together the learning from our COVID-19 casework under the same six headings.

This structure deliberately reflects our sense that organisations worked in new and different ways because of COVID. Traditional service structures and organisational boundaries had to break down to enable creative solutions.

The view we present of local services is inevitably focused on the actions of councils and care providers that have been complained about. To balance this out, we've also reflected what our casework told us about services delivered under pressure without fault.

The report summarises common issues identified through cases on which we carried out a full investigation. It also gives headline figures and trends from those cases where our initial assessment did not prompt full investigation.

The case studies in the report explain our findings and focus on our recommendations for service improvements. We have deliberately omitted personal remedies – the actions we asked organisations to take to address injustice caused to the persons directly affected.

This is because the report aims to encourage councils and care providers to learn and reflect on service improvement – we often find things have gone wrong for people when systems and good governance aren't underpinned by getting "the basics" right. Dealing with complaints is a key frontline service. Learning from complaints can often be free consultancy, shining a light on underlying problems with the potential to cause future injustice.

The report finishes with some suggested questions to help those responsible for scrutinising council and care provider services. Following this we present a bank of additional case studies from COVID-19 investigations not used in the main body of the report.

Our approach to complaints involving COVID-19

At the end of March 2020, because we recognised the impact the pandemic was having on councils and care providers, we decided to suspend our casework investigations for the first time in our history.

To deal consistently and robustly with the complaints we would inevitably see about COVID-19, we knew we would have to closely track the growing range of COVID specific legislation and guidance affecting the organisations we investigate.

We quickly created a specialist team of investigators to assess and investigate COVID-19 complaints. We developed internal guidance to support the team, and a new system of categorisation so complaints could easily be tracked.

This divided COVID complaints into two types:

- Complaints directly involving new legislation and guidance (for example changes to the support for children with special educational needs during the pandemic), which we termed 'primary COVID' cases; and
- Complaints where the pandemic and its impact on people and organisations was an extra difficult or aggravating factor (for example services like statutory noise nuisance, where rules didn't change but pressure on staff, and potential increase in cases during lockdown affected timescales). We termed these 'secondary COVID' cases.

We restarted investigating complaints at the end of June 2020 following a three-month pause.

COVID casework headlines

What period are we looking at?

All the analysis in this section covers the period of 1 April 2020 to 30 November 2021. With the first two months of that period seeing our casework largely suspended, in terms of our investigations it can be classed as the first 18 months of the pandemic (June 2020 to November 2021).

How many COVID-19 related complaints have we dealt with?

Between 1 April 2020 and 30 November 2021, we decided 1,123 complaints and enquiries from the public, which featured COVID-19 as a primary or secondary factor. We decided 505 of those cases with a detailed investigation.

As a comparison with our total casework, we decided more than 24,158 complaints and enquiries on all topics, with 6,056 cases decided by detailed investigation.

Figure 1 shows the number of all COVID decisions we made each month. These comprise complaints dealt with by an initial check, an initial investigation (assessment) and a detailed investigation.

Figure 2 shows COVID cases closed as a percentage of total cases closed. This has so far peaked at around 6.5% (May 2021).

Figure 1: COVID-19 cases (primary or secondary subcategory) closed in each month

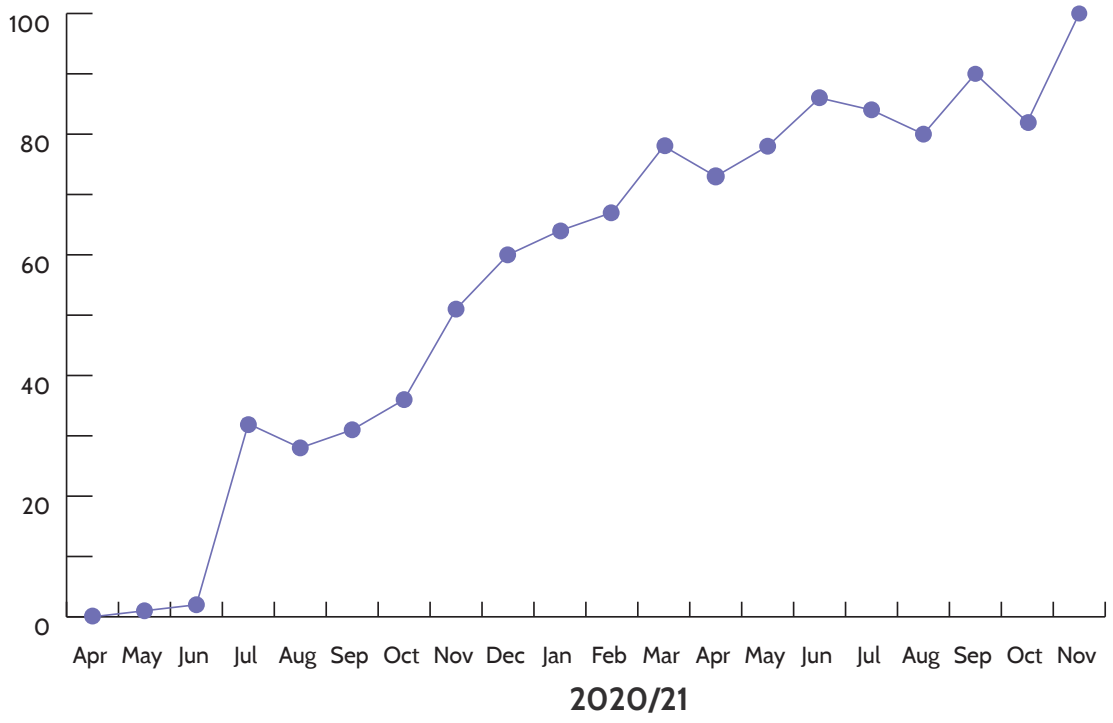
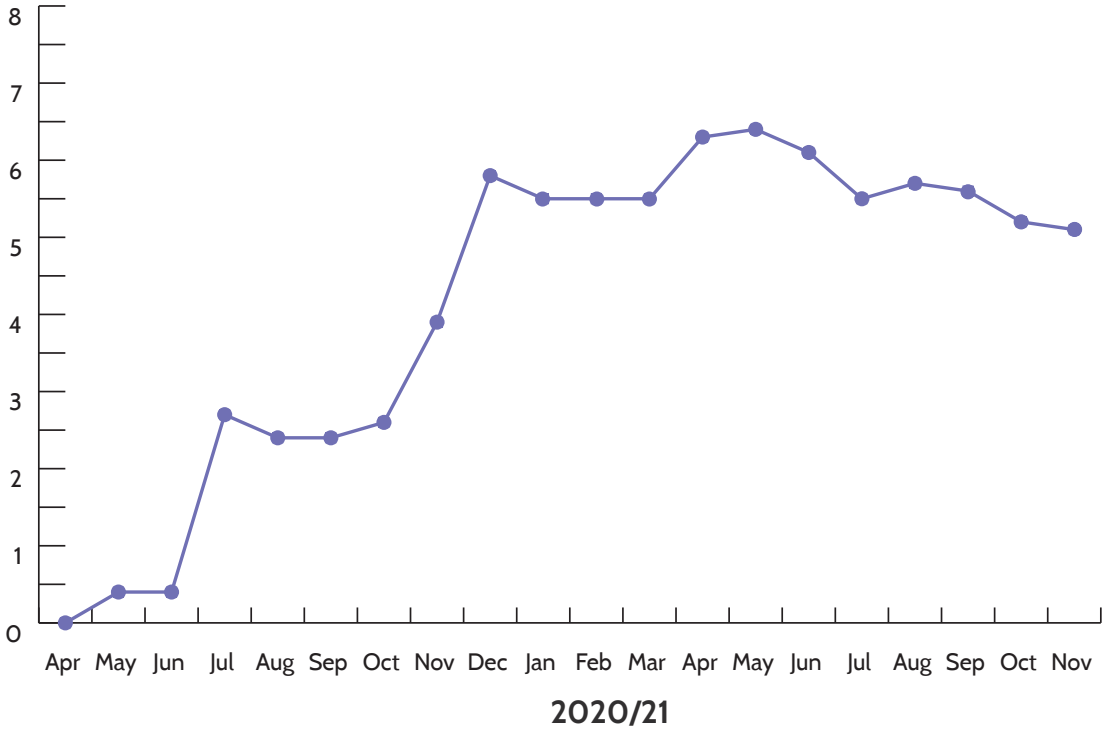


Figure 2: COVID-19 cases closed as a percentage of total cases closed



What types of COVID complaints have we investigated?

The main categories of COVID complaints we have investigated are:

- Benefits & tax (41%) – which have been almost exclusively about council decisions on business support grants introduced by the government to address the impact of lockdown on the economy
- Adult social care (20%) – which covers both care provided/commissioned by councils as well as by private sector care homes
- Education and children's services (12%) – which covers issues like school admissions and support for children and young people with special educational needs and disabilities (SEND)

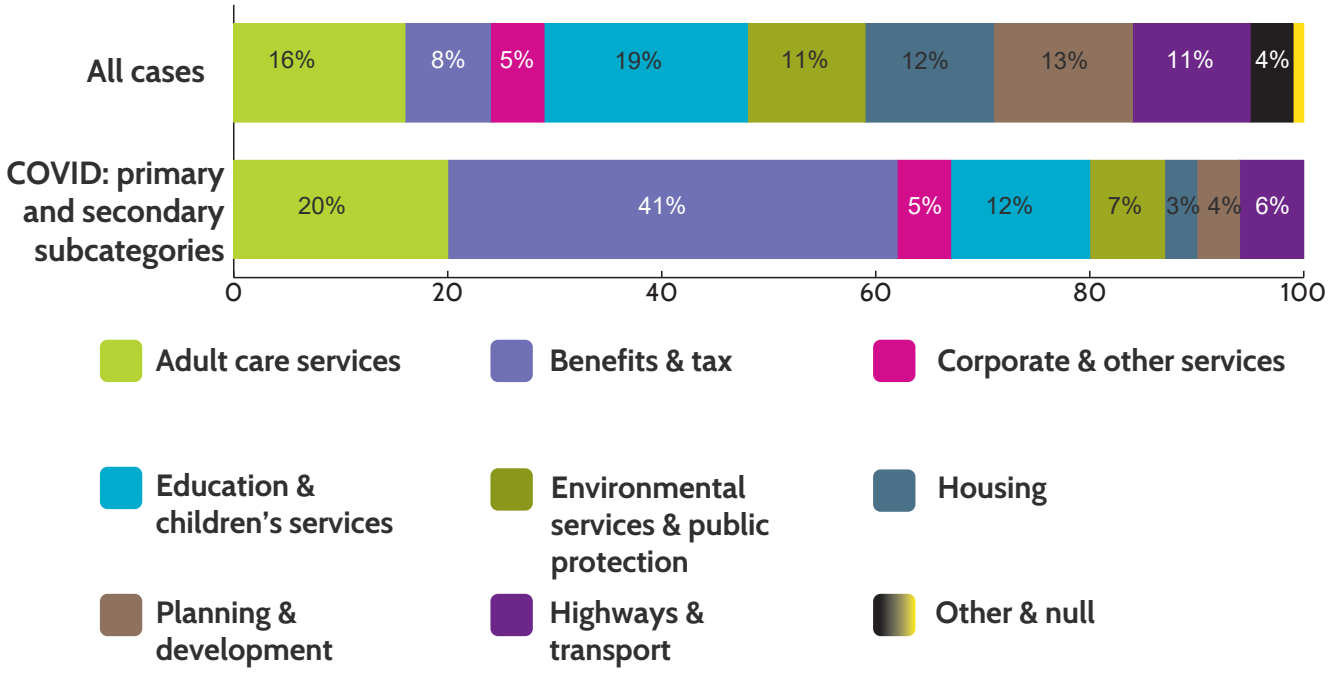
Smaller numbers of other complaints covering subject areas as diverse as planning, allotments, use of facilities (e.g. libraries and, in one case, a marina)

Figure 3 shows the balance of our COVID complaints is significantly different to the mix of subjects we look at in our 'typical' overall caseload.

By far the largest difference is the 41% versus 8% in Benefits & tax, swung by the influx of business grant complaints mentioned above. This category normally comprises mostly complaints about council tax and benefits.

The balance of COVID complaint types has been broadly stable over the eighteen month period. Education and social care complaints took a little longer to come to us, probably because they tend to be more complex and take more time to be investigated by the responsible organisations. Complaints about business grant decisions started at a high level and have sustained throughout the period.

Figure 3: COVID-19 case category distribution compared to overall category distribution of all cases



What are the outcomes from our COVID investigations?

There are different outcomes from our investigations:

- **Incomplete/ invalid**

For some enquiries we give advice the person should go to a different organisation better suited to address their issue

- **Refer back for local resolution**

Where the complaint has come to us before the organisation has had a reasonable chance to deal with it

- **Closed after initial enquiries (initial investigation)**

Where we decide not to investigate a complaint – for example because we decide there is not enough evidence of significant injustice, or we are unlikely to be able to add to the outcome of what's already happened or achieve what people want

- **Upheld/ Not upheld**

Where we make a finding of whether the organisation's actions have been at fault and whether it caused injustice. Where we find injustice, including potential future injustice to others, we can make recommendations to remedy the situation.

Figure 4 compares the distribution of outcomes from COVID complaints against our typical casework outcomes. We carried out more detailed investigations (45%) on COVID complaints than we did across all our work (25%).

On COVID complaints, we also made a significantly lower proportion of decisions that cases were incomplete or people needed advice to seek resolution elsewhere. This is likely to be because it was clearer to people that COVID complaints were for us to investigate compared with our full caseload which often includes clearly misdirected cases, such as complaints about banks or travel firms.

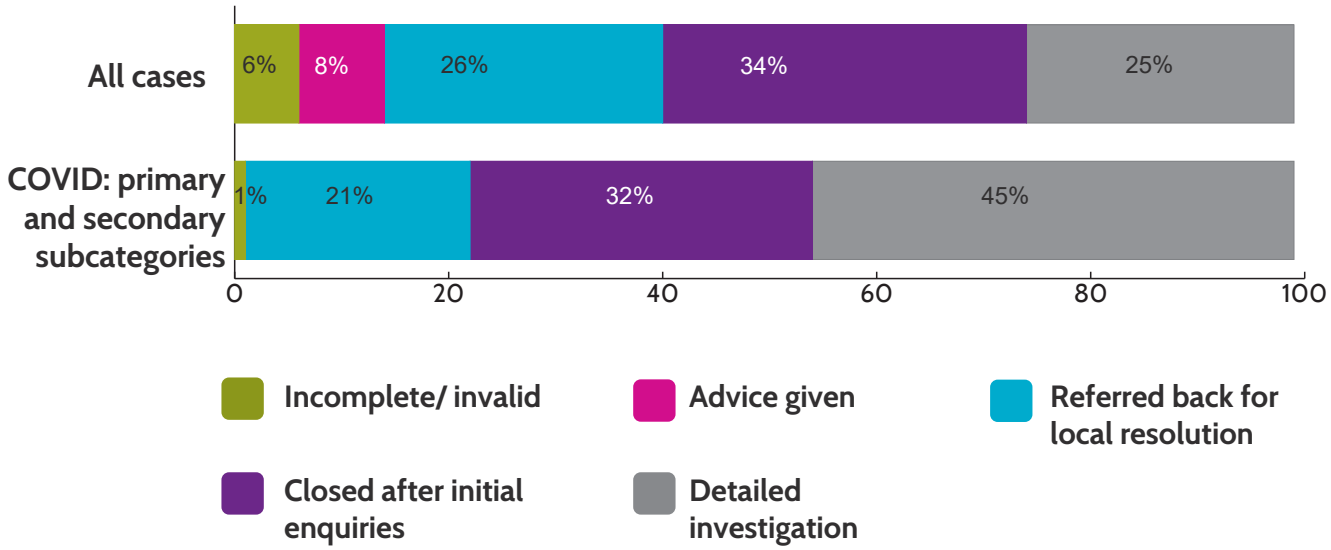
Whatever the outcome, our decisions are important for complainants and the organisations investigated.

We promptly identify the cases which others are better placed to consider, or when it is too early for us to carry out an initial investigation (assessment). This helps people to resolve their issue as soon as possible.

If we find the organisation has not been at fault, or the fault has not caused injustice, it can still bring closure to a situation and allow relationships to move on.

During our initial investigation (assessment), we can also reach findings of fault and injustice, and make recommendations to remedy this. This saves time by avoiding the need for a detailed investigation.

Figure 4: COVID-19 outcomes compared with normal casework outcomes



How many COVID related complaints have we upheld?

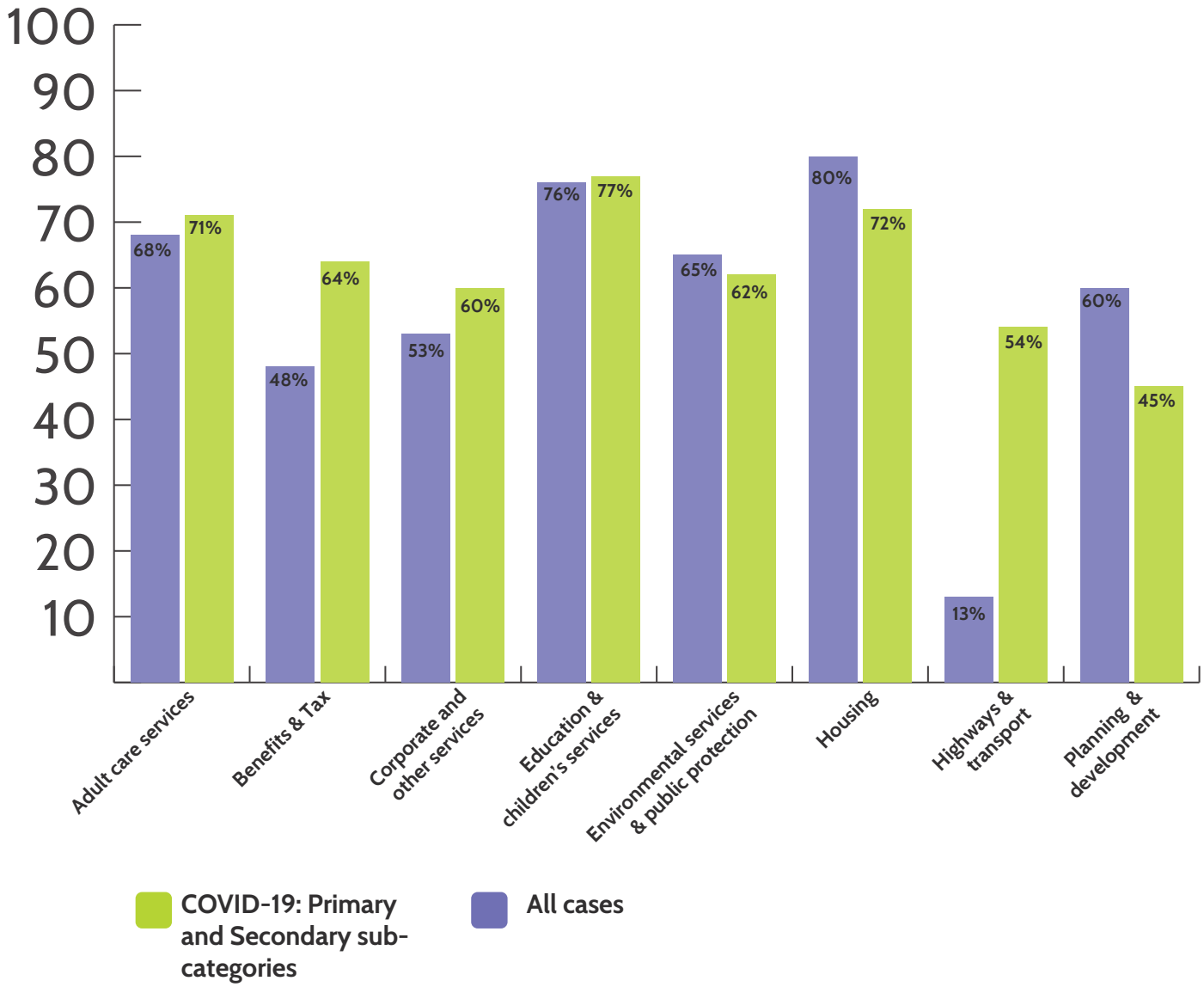
We uphold a complaint if we find fault in the organisation's actions, whether or not it caused injustice to the complainant.

We upheld 62% of the COVID complaints we investigated. This is slightly lower than the 66% of complaints we upheld across all our work. Within the overall COVID complaints uphold rate, we upheld 59% of complaints categorised as primary COVID cases – those that involved COVID-19 specific legislation and guidance.

Most of our upheld decisions are a result of a detailed investigation. However in several COVID cases, about business support grants and environmental services, we decided to uphold complaints after an initial investigation (our assessment stage). This was usually because the council accepted fault and there was likely no additional value in us investigating further. We include some of these case studies in this report.

Figure 5 shows uphold rates for different types of COVID complaint, compared with all our work. The noticeable difference is in highways and transport (13% versus 54%). However, due to the low number of COVID decisions on this topic, the proportional difference is not statistically significant. Otherwise, we had broadly similar uphold rates for COVID related complaints compared with typical casework. This chimes with our overall conclusions: that the pandemic broadly led to similar types of complaints as we normally receive, which is a testament to how organisations responded well to the unprecedented pressures of the last eighteen months.

Figure 5: Uphold rates



COVID Casework: principles and case studies

Principles of good administrative practice

1. Getting it right – the basics

Our expectations

It might be tempting to view the basic principles of good administration as disposable when facing extreme pressure – things like accurate record keeping and properly documenting how decisions are made. But we argue the basics are more important than ever in a crisis; they remain essential building blocks of effective decision making.

Our guide on Good administrative practice during the response to COVID-19 ('our guide') said:

- Basic record keeping is vital during crisis working. There should always be a clear audit trail of how and why decisions were made, particularly summarising key reasons for departing from normal practice
- When you are working with new organisations to deliver services during COVID-19 or using existing partners in new ways, ensure your organisation keeps proper oversight and direction. When you delegate responsibility to others (e.g. the voluntary sector), responsibility remains with your organisation
- Where COVID-19 is causing you to devolve decisions to a more local level, make sure those decision makers can access prompt, appropriate legal advice where necessary
- When moving staff from less immediately critical roles into frontline services, care should be taken that this does not undermine the organisation's ability to maintain essential services

What we found

Adult social care – cases involving councils and care providers

We found faults with:

- Care plans not being properly developed and/or reviewed as circumstances changed during the pandemic
- Inadequate record keeping of care provided to people during lockdown meaning uncertainty about how they were supported
- Pre-existing delays and backlogs in service delivery exacerbated and compounded by the impact of COVID-19 meaning important actions further delayed

Case reference: 20 004 806

The complainant's mother was not properly cared for by care workers visiting her home during the pandemic. We found she was often kept waiting for them to arrive and was therefore unable to get up and take her medication. The care provider sent a care worker with COVID-19 symptoms despite agreeing this should not happen.

We found the care provider had not reviewed its support plan to manage expectations, when it struggled to deliver the care package during the pandemic. We also found it did not make sure carers self-isolated when suffering from COVID-19 symptoms.

Recommendations to improve

The care provider agreed to review care packages in future when it has problems delivering them.

Case reference: 20 006 019

The council took more than two years to consider important adaptations to a man's home so he could safely live there, which was required because of his health problems. Some of the delay was because of the pandemic, while some pre-dated it.

We said the process took at least 14 months longer than it should have, even taking into account the inevitable impact of the pandemic on the council's services. The council's policy had no timescales for completing the work.

Recommendations to improve

As a result of our investigation the council agreed to do a comprehensive action plan, involving scrutiny by elected councillors, to fundamentally review its approach to occupational therapy assessments and how it prioritises casework.

Case reference: 20 014 255

We found the care provider commissioned by the council failed to look after an elderly woman properly. She caught COVID-19 and died from it at the care home. The home rarely recorded her temperature, despite knowing it needed to. It kept poor care records; there were contradictions and gaps. It did not follow government guidance about seeking medical advice when the woman was in isolation after catching COVID.

The Care Quality Commission (CQC) had already identified problems with infection control at the home at the time. In correspondence with the family, the provider misrepresented its findings, intimating there were issues only with its record keeping rather than its measures to control the spread of infections too.

Recommendations to improve

We asked the council to work with the home to develop an action plan to improve record keeping and its approach to seeking medical advice. The home was already acting on infection control measures.

Benefits and tax – cases about financial support for businesses affected by COVID-19

We found fault with:

- Providing information to applicants that adequately explained priorities and timescales of COVID-19 grant schemes and other support
- Keeping adequate records to explain decisions about approval of grants – leaving businesses uncertain why they had not been supported

Case reference: 20 006 059

A business applied for a small business COVID-19 grant in summer 2020. The council refused the grant, saying the business was not eligible because it did not occupy business premises. The business then applied for a discretionary grant which the council refused, saying the application was out of time.

We found the council's website did not explain businesses had to apply for discretionary COVID-19 grants within a certain timescale. It was not clear enough about this critical detail. The business went to the trouble of making an application that it might not have made, had this been clear.

Recommendations to improve

The council agreed to consider future complaints about decisions rejected on the same basis, taking into account our guidance on remedies, and would signpost people to us if they remained unhappy.

Case reference: 20 013 446

The council knew a business had moved outside its area. Yet it told the complainant, who had applied for grant assistance, that it would pay him a top up grant after making an initial payment. The man then made important business decisions based on that assurance. The council kept no records of how it made decisions about the criteria for awarding top up grants. It then refused to pay the man when it realised his business was no longer operating in the area. However, there was no policy on which to base this decision and it was contrary to what it had told him.

Recommendations to improve

The council agreed to train staff to ensure they keep timely records of decision making and publish relevant policies in future.

Education & children's services: school admissions

We found typical faults we see during normal times, but these were made worse by COVID-19 special working arrangements. For example, poor record keeping of appeals and failing to adequately explain reasons for dismissing appeals had more of an impact in some cases because councils were running hearings online.

Case reference: 20 002 298

We found several faults in the school admission appeal panel hearing, acting under COVID-19 rules.

A panel member attended only part of the hearing because of illness, an officer made inappropriate interventions and the clerk and chair failed to intervene when panel members also made inappropriate comments.

The decision letter did not adequately set out the decision and was not signed by the clerk or chair.

Special Educational Needs

The education of children with Special Educational Needs and Disabilities (SEND) was particularly, and in some cases unavoidably, disrupted during the COVID-19 lockdown restrictions. For a limited period, the government allowed councils to suspend their normal absolute duty to secure provision required by Education, Health and Care (EHCP) plans, replacing this with a need to make "reasonable endeavours".

We investigated several complaints about these matters, finding faults where councils failed to properly record or show how they had considered reasonable endeavours. We also found examples where the impact of pre-existing delays in carrying out assessments before the pandemic was worsened by what then happened. This meant children avoidably missed out on important provision.

In other cases, we found councils had failed to keep parents properly informed of changes in provision and delays in securing that provision. This caused them distress and uncertainty about what was happening and the options available to meet their children's needs.

Case reference: 20 003 475

We found the council had taken too long to act on concerns raised by a mother about the special educational needs provision her son was getting at their school during the first lockdown.

During the period covered by the 'reasonable endeavours' duty, it failed to identify, record or share which parts of the plan would be delivered. It did not show how it had used reasonable endeavours to ensure the young man got the support he required.

In this case we did not make service improvement recommendations as, by then, the reasonable endeavours duty had ended.

Case reference: 20 001 515

We found no evidence the council had carried out risk assessments to see what parts of a vulnerable young man's EHC plan could be met at home, or another safe setting, during COVID-19.

The council made no effort before lockdown to enable a therapist to work with the man. This meant they were not ready to do so once lockdown started. It failed to follow this up or decide whether another therapist could work with him.

We decided the council did not use reasonable endeavours to provide support. It resulted in the young man missing out on direct support from the therapy, as well as indirect support due to teachers and support assistants not having the training from therapists required to help him.

Case reference: 20 000 627

The complaint covers the period of lockdown during which councils had to make reasonable endeavours to provide the special educational needs set out in a young person's EHC Plan.

We found the council failed to set out which elements of special educational provision in the plan would be provided by the school. It also failed to explain how the available support would be different from that required by the plan. This was despite repeated requests for this important information. This caused frustration and meant the parent did not know in any detail what support his son would receive.

Recommendations to improve

We decided not to make service improvement recommendations because the period for risk assessments had, by then, passed.

Case reference: 20 005 883

The council delayed issuing an EHC Plan for a young man with multiple special educational needs. This delay happened before the temporary COVID-19 law changes came into force, so the council still had to secure provision and make reasonable endeavours to put this in place. We found the council provided no evidence it had done so.

The council also failed to send an amended final plan to the man's college after term had ended. This meant the college did not know about the increased support in the new plan. The man missed out on the chance to have extra provision in place, even if this had to be delivered remotely because of the pandemic. The council was also seven months late carrying out an annual review, by which time the man had left college. It also failed to plan for the man's transition to adult care or to deal with the complaint properly.

Recommendations to improve

The council agreed to review procedures for sending plans to schools and colleges, and for checking provision is in place. It also agreed to review its checks on annual reviews, especially at key stages in a person's education.

Housing: Homelessness

At the start of the pandemic, some of the most acute needs were experienced by people who were homeless. Councils were given time-limited resources and powers under the “Everyone In” initiative to get people off the streets and into safer accommodation.

However, in one high profile case summarised below, we identified a succession of faults causing significant personal injustice to a homeless family during the pandemic.

Case reference: 20 004 585 (public interest report)

A teenager was left to sofa surf and live in a tent for almost two months during the pandemic after his family was left homeless. The council missed at least five opportunities to house the teenager and his mother during the summer of 2020.

When the mother first approached the council, it decided it had no duty to house her and her 16 year old son under its homelessness obligations. But it placed the family in temporary accommodation because of its child protection duties.

The family became homeless in July 2020 when the children’s services department asked them to leave the temporary accommodation. In making the family homeless the council failed to consider government guidance which asked landlords to work with renters who may experience hardship as a result of the pandemic. The council then failed to take action despite contact from the mother and the homelessness charity Shelter.

Recommendations to improve

As well as personal remedies the council agreed to provide refresher training for staff to ensure they understand their duties under the Housing Act.

2. Being service user-focused - individual circumstances

Our expectations

Organisations should properly consider someone's individual circumstances and not rely on inflexible blanket policies that treat everyone the same. They should also consider whether any reasonable adjustments are required to help someone access the service.

We recognise pandemic working required councils and care providers to adapt and create new and fast changing rules, thresholds and triaging of services. But this should not come at the cost of properly considering how these new processes apply to individual circumstances.

Our guide said:

- Where new or adapted policies and procedures are brought in, ensure frontline staff are clear about any new expectations so they can give the right advice to service users
- Even when national rule changes allow raised thresholds for action, ensure you properly consider the individual circumstances of each case
- Emergency working will cause backlogs in access to many, now lower priority services. Try to plan ahead so there can be a phased return

What we found

Adult social care – cases involving councils and care providers

We found faults with:

- Significant delays carrying out Care Act assessments, sometimes preventing or delaying moves out of hospital, or moves between providers
- The needs of people receiving care not being put at the centre of decisions about what happened
- Rules governing the use of personal protective equipment (PPE) not being adhered to and/or fast changing rules and procedures not always being adopted throughout an organisation's practice
- Failure to adapt promptly to the opportunity to reopen services as restrictions relaxed – including relaxing visiting rules as the country emerged from national lockdowns
- Difficulties prioritising key decisions about longer-term care during the pandemic
- Inflexibility about the creative use of direct payments to secure appropriate care when normal provision was affected by lockdown
- Unclear advice to relatives about visiting people in care homes at end of life

Case reference: 20 005 598 (Joint health and social care decision)

The care provider suspended a vulnerable woman's home care package because of the pandemic. We decided this was not in keeping with regulations regarding person centred, safe and dignified care. The woman was left without care for five days, meaning family members had to provide the care which should have been done so through her package.

The Clinical Commissioning Group (CCG) was responsible for ensuring the woman got the care she required. We found it failed to give the necessary advice and did not seek advice from the council infection control team. Its advice to the care provider and family was contrary to personal, protective equipment guidance and regulations.

The council's closure of a safeguarding case was contrary to statutory guidance. It did not explore the decision making that led to the suspension of the care package or to seek advice about infection control.

Recommendations to improve

The care provider and CCG agreed to draw up action plans to improve guidance about homecare provision during the pandemic, and ensure they met that guidance when commissioning care.

Case reference: 20 011 457

The care provider failed to escalate the case when a woman's health deteriorated while at home during the pandemic. It failed to follow the steps in its own policy, agreed during the pandemic, to ensure the woman was assessed by an appropriate clinician.

We found the woman not being able to die in familiar surroundings with her family around her was a tragic situation. However, that was essentially due to her unforeseeable decline and the COVID-19 restrictions limiting hospital visitors and the transferring of patients back to the community. This was not within the care provider's control.

We could not say different action would have resulted in a different outcome. But the care provider's response to the family's complaint was inaccurate. Its actions caused the family avoidable distress and confusion at an already traumatic time.

Case reference: 20 006 454

The care provider looking after a woman in her home, did not take reasonable steps to manage risks of infection during the pandemic. Its risk assessments about staff using personal, protective equipment were not specific or detailed enough to show it had properly considered potential risks from COVID-19.

Recommendations to improve

As a result of our investigation the provider agreed to develop a policy to ensure concerns raised by service users were recorded, risk assessments for using PPE were completed and records of actions at care visits were kept.

Case reference: 20 004 578

The council was responsible for a range of support services, including a day centre, for a young man with a range of care needs.

When he was unable to access the support required by his care and support plan for a time during lockdown, the council failed to communicate properly with the family about what was happening. This left them having to find out what services were available elsewhere and increased their anxiety about the situation. It also meant the man did not return to the day centre as soon as it reopened and was willing to accept him.

We found the council had failed to communicate as effectively as it should with the family. It agreed to learn lessons from what had happened.

Case reference: 20 005 651

An elderly man died at the care home during the pandemic. We found the home followed guidance about restrictions on family visiting arrangements but should have been clearer with his daughter when it decided to stop her visiting.

This fault caused her distress about whether she could have been with her father at the end of his life. In its complaint response, the care home said it had not told the family they could not visit. This contradicted its own records, which show it did.

Case study: 20 001 450: (Joint health and social care decision)

A care home was looking after a woman in the final days of her life during the early weeks of the pandemic. She needed palliative 'just in case' medication to ease her pain. It is not clear whether COVID-19 was a factor in her illness.

We found the care home did what it could to obtain the medication. But when it arrived, it did not chase up the NHS hub to get a community nurse to administer it, although this would not necessarily have resulted in someone attending sooner. We found the GP surgery failed to appreciate the urgency of the situation when contacted about drugs. It did not tell the home how to get an urgent appointment so the medicine could be administered. We found the NHS Trust did not follow its usual referral process.

These collective failures caused avoidable pain and distress for the elderly woman in the last days of her life. She had to wait until the following morning for the medication. The family also suffered avoidable distress of seeing their mother in significant pain at a traumatic time.

Recommendations to improve

The care provider agreed to remind staff of the process to get urgent, end of life medication. The GP practice agreed to ensure staff are aware of the need for an emergency appointment when anticipatory medicine is needed.

Case reference: 20 011 374

The council gave direct payments so that a young adult with learning disabilities could access a personal assistant to help at the weekend, when the young person wasn't at college.

It made no attempt to contact the family during the first COVID-19 lockdown to see how they were coping. We said if it had, the family would likely have explained that lockdown, shielding and ill health meant other family members had to step in. The council did not act in accordance with the ethical framework for adult social care. It had not been inclusive or supportive, or considered the exceptional circumstances affecting the family.

Case reference: 20 008 271

The council gave misleading information about what it could do to help a woman whose care needs were affected by the closure of day centres and respite care during the pandemic. The council said it could not compel centres to open but in fact it had decided how the centre relating to the complaint would reopen, and who it would provide services for.

It failed to keep records about its decision making, and was too slow to start planning for re-opening day centres after the pandemic, after taking too long to produce risk assessments and meet providers.

Case reference: 20 005 645

A young woman with learning and physical disabilities had a package of care and support arranged through the council. Her family used direct payments to pay for personal assistants to help them with this.

During the pandemic the family stopped using the assistants in accordance with government advice about limiting visits to the home to reduce the spread of infection. They continued to pay for them because they wanted to use them again after the COVID restrictions were lifted. They asked the council if they could use the direct payments more flexibly to pay family members to provide the care the assistants would otherwise have done.

The council decided they could not do so. We said this was not in line with government advice, which encouraged flexibility and relaxing restrictions on the use of direct payments during the pandemic. We said the council needed to reconsider its decision.

Case reference: 20 007 901

An elderly man living in a care home provided on behalf of the council became unwell at the start of the pandemic. He was taken to hospital for overnight checks. After he returned to the care home his health deteriorated and he died from COVID several days later.

Gaps in the care home's records meant we could not be certain about what happened in the final hours of his life and whether someone was with him when he died. Records show regular checks and care for the man, but the provider's poor record keeping means his daughter cannot be sure what happened in the final hours of her father's life.

Recommendations to improve

As a result of our investigation the care home has improved record keeping and how it talks about end-of-life care planning with families.

Case reference: 20 007 217

A man with a range of care needs lived with his family. Before COVID, he went to a council run day centre several times a week and his family met his care and support needs outside that time.

After day centres closed during lockdown, the family was concerned about how the loss of support affected the man. They helped look after him. Then they asked the council for help when the man's father became ill. The council offered to arrange support but introducing this became held up by discussions about an assessment. It meant the father lost out on important help.

The council is now reassessing people to understand the impact COVID-19 has had on them and their families and carers to see if it has affected their assessed care needs.

Case reference: 20 010 666

A care home used a definition of end-of-life care that was too narrow, to prevent family members visiting their mother during the pandemic as often as should have been possible before her death. We found the home regarded 'end of life' as being linked to the prescription of specific medication given at the 'very end' of life, rather than the wider definition expected by government guidance.

It should have been clear that when the woman started refusing food she was approaching the end of life. The provider should then have reviewed visiting arrangements. Instead, it made the irrational decision to require the family to rotate their visits, thereby increasing the number of people visiting.

Recommendations to improve

We recommended the home improved its approach to how it planned for end-of-life care, acting before the very end of life.

Benefits and taxation – cases about financial support for businesses affected by COVID-19

We found fault with:

- Blanket decision making about the eligibility of certain business sectors, rather than appropriate consideration of specific circumstances
- Inflexible application of guidance where appropriately broadly similar businesses were treated differently for support

Case reference: 20 012 112

The council decided not to pay an otherwise eligible business a COVID small business grant because it did not have an email address. We found this was fault. The business was entitled to access the fund. It did not need to apply.

Although the pandemic meant the council needed to make quick decisions it should have been more flexible to allow access to a grant the business was entitled to get. The council's requirement to make an online application was its administrative convenience. Its decision not to accept any other type of application was against our good administrative practice principle of being user-focused. There is no evidence the council attempted to consider the woman's circumstances.

Case reference: 20 005 499

The council withdrew COVID-19 rates relief and a retail, hospitality and leisure grant from a man's business. The government gave councils wide discretion about how to apply the discount and award grants. But we found the council took a blanket approach to its decisions about the discount and grant, which were based on information from the Valuation Office Agency's rating list.

The council did not give notice to businesses that it could remove the discount and grants after further checks. For this business, it awarded and then removed the discount and grant without explaining or giving any reasons. This caused confusion and uncertainty, and probably influenced subsequent decisions made by the business. There were also significant delays dealing with the complaint. However, we did not find fault with the council's decision making in withdrawing the discount and grant, with it having taken all relevant information into account.

Recommendations to improve

The council agreed to train staff so they were aware of, and would take account of, our principles of good administrative practice in future.

School Admissions

As school admissions authorities, councils were given certain flexibilities and freedoms around how they held school admission appeals during the various phases of lockdown.

We found fault with:

- Insufficient notice to appellants, problems checking if parents could use online technology to access panel meetings and failing to give parents enough time to consider officer evidence
- Securing adequate access for everyone to important background information
- Not properly considering whether to make reasonable adjustments to enable access to virtual hearings

Case reference: 20 002 869

A school admission appeal panel considered an appeal under the COVID-19 remote working arrangements. We found the council delayed sending the father a copy of the relevant papers so he did not have time to prepare his case.

He asked the panel for patience at the hearing because of a head injury affecting his participation. We found the panel failed to properly consider whether it needed to make reasonable adjustments to how the meeting was held, so he could participate effectively.

Recommendations to improve

Because of our investigation the council has reminded clerks and panel members of their duties under the Equality Act.

Case reference: 20 001 337

The council did not give notice of a school admission appeal panel to a woman, so she missed out on making her case at appeal. This was likely because the council was training and supervising new staff in the COVID-19 emergency appeal working arrangements.

We were also concerned the appeal panel decided to hear all hearings based only on papers. It needed to record its reasons for not holding remote panels. It needed to show it was not taking a blanket approach but was open to considering individual circumstances, and took proper account of the needs of applicants who might have difficulty making their case in writing alone.

Recommendations to improve

The council agreed to review its arrangements and ensure it recorded reasons about whether to hold remote hearings individually for each case.

3. Being open and accountable – evidence-based decisions

Our expectations

Even in a fast-changing environment of emergency working, decisions affecting people's lives need to be rooted in easy to access, transparent and relevant rules.

Our guide said:

- The basis on which decisions are made and resources allocated, even under emergency conditions, should be open and transparent. Any new criteria, thresholds and timescales should be clear to service users and staff
- Decision reasons should be clear, evidence based and where necessary explained in the particular context and circumstances of that decision
- However, normal expectations on the need to consult service users and stakeholders may not be feasible or appropriate. You should document and explain departures from normal practice

What we found:

Adult social care – cases involving councils and care providers

We found fault with:

- Confusing changes and fluctuation in care, sometimes without consultation required by the Care Act
- Various problems with transfers between hospital and care, and between different care providers, particularly involving reablement

Case reference: 20 011 918

The council arranged an emergency placement in a care home for a woman, so she could be quickly discharged from hospital at the start of the pandemic. This was part of the Government's 'discharge to assess' programme aimed at freeing up hospital capacity to prepare for COVID related admissions. This programme meant the NHS would fully fund the cost of new or extended out of hospital health and social care packages.

The council had already begun to plan for her discharge before the pandemic started. We found that, once the 'discharge to assess' procedures came into effect, the council should have decided they superseded its planned arrangements and taken steps to arrange an immediate discharge.

The woman became unwell and could not be discharged until later. She was eventually discharged from hospital without the family being consulted and not in line with the planned discharge arrangements. During our investigation the council agreed to waive charges.

Case reference: 20 004 145 (Joint health and social care decision)

A woman in her 80s needed reablement care (care to help her regain her independence) after being discharged from hospital in March 2020 following a bone fracture.

Before being in hospital she had been able to live independently in her home. She went back into hospital and came out in May, again needing help with reablement. The council failed to explain reablement care was time limited, could be reviewed and stopped even during the COVID-19 period, and that it would charge for any long-term care. The clinical care group's correspondence tried to be helpful about care charges but its references to free care at the end of the emergency period were misleading.

Recommendations to improve

To prevent similar problems reoccurring, the council agreed to keep better records of planning conversations with service users and families. The clinical care group agreed to take action to improve the accuracy of its information on this matter.

Benefits and taxation – cases about financial support for businesses affected by COVID-19

We investigated a lot of complaints about council decision making. Many concerned faulty, unclear or inconsistent reasons for rejecting grants or support.

In particular, we found fault with:

- Not properly considering evidence provided in support of applications
- Explaining reasons for supporting certain business sectors and not others
- Giving inaccurate information about criteria on websites

In two council tax cases decided by an initial investigation at our Assessment stage, we found the council communicated poorly about changed arrangements for payments and arrears during COVID.

Case reference: 20 000 762

The complainant had a retail business and wanted to apply for support in March 2020 when he was affected by the lockdown. We found, in our initial assessment of the complaint, that the council's website inaccurately described eligibility for grants. It wrongly implied the man's business was eligible.

The man applied and was refused. He therefore had gone to wasted effort and the council had wrongly raised expectations, causing him distress. Crucially, had he known he was not eligible for a grant, he would have furloughed staff and suspended trading, instead of trying to keep trading.

Recommendations to improve

The council improved the information on its website because of our investigation.

Case reference: 20 001 009

The council did not properly consider evidence which showed a business owner both occupied and used the property for his business. It confused two grant schemes and took account of irrelevant information that had no bearing on the man's entitlement to support, including where he lived, if he had council tax arrears and the amount of customers his business appeared to have.

In contrast the council ignored relevant information he provided including a utility bill. It failed to explain why it rejected other evidence provided and, when challenged, relied on its evidence without reference to apparently contradictory evidence. It did not give clear, evidence-based reasons for its decision.

Recommendations to improve

The council agreed to train staff to ensure they give clear, evidence based decisions in the future.

Case reference: 20 001 522 (public interest report)

In March and May 2020, the government introduced grant schemes to support businesses affected by the pandemic. We were contacted by two small business owners who complained about the way the council had handled their grant applications.

We found the way the council recorded how it decided the amount it would grant businesses lacked transparency. It decided it would favour some sectors over others but did not publish this information. It also gave more weight to the business sector than it did to the size of the business or their costs and losses. This was despite saying these were key deciding factors. The council therefore raised some small business owners' expectations that they may receive grants of up to £5,000 when this was rarely the case.

We found inadequate record keeping for explaining the council's individual decisions. There was also inconsistent decision making, which raised concerns about the way it allocated its grants. At times, it made awards to businesses in direct contradiction to the rules of its scheme.

Recommendations to improve

The council scrutiny committee agreed to carry out a lessons learnt exercise to ensure, if it was asked to run a similar scheme, it would develop an open, transparent and consistent approach.

Case reference: 20 007 466 (Assessment decision)

A woman paid her council tax by posting a cheque to the council every month. After lockdown the council decided to stop processing cheques to reduce the amount of people visiting its offices. It did not tell her about the change.

The woman kept sending cheques. The council wrote to her saying it had not been able to process cheques but didn't explain the situation clearly. It used confusing language and omitted reference to many attempted payments. Consequently, the woman faced a large unpaid bill she had not expected, having assumed cheques had been cashed.

Case reference: 20 013 458 (Assessment decision)

A man owned an empty home and intended to do work on it so he could rent it out. The pandemic bought work to a halt. The council then increased its council tax in line with its policy on empty properties.

The man asked to pay less council tax because of the unavoidable impact of COVID restrictions on building works. The council failed to treat this as a request for a discretionary discount or suggest he applied for one. This stopped the man having the opportunity to have any such requests considered and the right to appeal decisions he disagreed with.

Highways and transport – traffic management schemes

We considered a handful of complaints about how councils introduced experimental traffic management schemes, which COVID-19 rules gave greater flexibility for.

While few in number, they highlight some important insights into implementing schemes effectively at short notice.

Case reference: 20 005 894

The council introduced two experimental road traffic orders which allowed increased pedestrianisation as part of its response to COVID-19. We recognised the unique circumstances and government guidance to develop schemes favouring cyclists and pedestrians. We also recognised the importance in the guidance of councils acting quickly and without necessarily going through all the consultation normally expected.

We found the council had appropriately consulted on the proposals and kept a record for some of its decisions. But it could not show why it had closed some roads to through traffic. It kept no record of how it considered potential impacts on important road users. There was no record of how it considered its responsibilities under the public sector equality duty regarding the impact on different users. Its consideration of this important matter was generic and cursory, particularly on older people.

Recommendations to improve

It agreed to carry out a review of lessons learnt from the complaint as part of a wider review of its decision making and record keeping in all aspects of its response to the pandemic. This is excellent practice and worthy of consideration by all organisations under our jurisdiction.

4. Acting fairly and proportionately – right framework for decisions

Our expectations

We anticipated that emergency working would mean adapting thresholds, eligibility criteria, timescales and other foundations of good administration. We expected it would not be possible or practical to consult as widely, or for as long as normal, on implementing them.

We also thought some of these changes would be attractive prospects for organisations in the long term, for example online meetings. While innovation, as a result of the crisis, could lead to improved working, we said this should not override the requirements of legislation, guidance and good administrative practice.

Our guide said:

- If you use new or revised policies and processes, this should not lead to arbitrary decisions and actions. Ensure you have a clear framework for fair and consistent decision making and operational delivery
- Decisions to change practice without consultation should be documented. You should commit a timescale to review any new practice to ensure exceptional working doesn't become the new normal

What we found

We found relatively few examples of fault relating to this principle. Based on the evidence of our investigations, it suggests organisations introduced new or revised policies and processes during COVID with due regard to good administrative practice.

Benefits and taxation – cases about financial support for businesses affected by COVID-19

In government rules covering discretionary support for businesses, councils were given considerable flexibility to decide which types of business to award grants.

Even taking account of this local choice, we found faults with:

- Councils not explaining why they made decisions, which led to confusion and uncertainty
- Confusing eligibility (whether a business was entitled to a grant) with prioritisation (whether, given limited resources, the council should approve a particular application)

Case reference: 20 002 489

The complaint was by a charitable business running conference facilities and space for worship. The council refused to award a grant for small businesses during the COVID-19 response. It said it did not consider a charity could run this type of business, that the business was not a type listed in guidance and that it had unlimited discretion to refuse a grant.

We found the council failed to explain its decisions to say the business was not eligible. It interpreted guidance too rigidly and did not think about whether the business was broadly similar to those set out in government guidance.

Case reference: 20 004 146

The complaint was about a grant application by a sole trader renting a serviced office with access to some shared office space. The council refused a COVID-19 support grant. We found it failed to properly explain its reasons for this. The council confused eligibility (about whether the business was a type eligible for support) with its choice about prioritisation (which types of business the council decided to give most support to).

Government gave councils wide discretion about what types of business to prioritise. But its guidance said nothing about situations where businesses in shared accommodation were not a priority. The council did not consider this important issue and did not think about whether the business was broadly similar to those cited by guidance as a priority.

Recommendations to improve

The council agreed to improve the wording of any subsequent policies to ensure they properly separate eligibility and priority.

Adult social care

We found some examples of changes to practice where consultation did not appropriately consider whether it was reasonable to make adjustments for people with disabilities.

Case reference: 20 010 883

The council decided to close its "moving on" service during COVID-19. This was a preventative drop-in service for people with acquired disabilities and long term health conditions. After consultation, it replaced face-to-face support with online engagement events.

We found the council did not properly consider the additional difficulties faced by people requiring adjustments. It did not consider or provide more accessible alternatives so they could take part in the consultation. It was likely the client group of the service would have problems accessing the consultation.

Recommendations to improve

In response to our investigation the council agreed to invite the complainant and other attendees to participate in consultation on the strategic review of the service and it is looking carefully at how to effectively engage with this group throughout consultation design.

Environmental services & public protection: Licensing

We received few complaints about licensing matters during COVID restrictions. This contrasts with the national situation regarding vehicle licensing delays which has been a source of considerable challenge and complaint. Where we did investigate, we typically found councils had acted without fault.

Case reference: 19 019 963

The complainant was about a council decision not to accept a man's application for a taxi license. The council decided to temporarily stop accepting evidence of NVQ qualifications as meeting training requirements during the early stages of the pandemic. It was entitled to take this approach. The council told us it would review this again when the situation changed. We decided not to investigate further.

Environmental services & public protection: Social distancing

Lockdown introduced new powers for councils to give people advice about social distancing.

Media coverage focused on the actions of council COVID marshals to advise and, outside our jurisdiction, police officers to enforce social distancing. We have received very few complaints on this topic, despite it being high profile in the early stages of lockdown.

This probably reflects a smooth introduction and operation of such measures and/or a recognition by the public that actions were proportionate and reasonable in the context of the pandemic.

In one case, which we did not to publish to protect the anonymity of the complainant, we said it was unlikely we could add to the outcomes of the council's investigation, which said its marshals had likely exceeded their powers in preventing cycling in an area.

5. Putting things right – when it goes wrong, put it right

Our expectations

We recognised that dealing with complaints might have been a lower priority for a time during the crisis.

But complaints can be an excellent early warning sign for important things going wrong. They can be particularly important when numerous changes to normal practice are taking place.

Our guide said:

Although complaint handling capacity will probably be reduced for a time, it is important authorities can still deal effectively with the most serious and high-risk issues that are brought to them

Authorities should:

- **Inform** – being realistic with complainants about the timescale for a response to their complaint. Let them know if there is going to be a further delay
- **Consider** – try to avoid blanket delays in dealing with all complaints. Consider each complaint on its merits. If you need to prioritise complaint responses, consider the impact
- **Explain** – delays and deviations from processes are understandable at this time. Make sure you can explain the reason for any delay or deviation from a process to the complainant and you have documented your reasons
- Plan a return to normal in complaint handling, making sure the crisis does not turn into longer term erosion of the organisation's capacity to listen to concerns

What we found

Adult social care

We found examples of poor handling of complaints exacerbating the impact of faults in the care itself.

Case reference: 20 011 149

A vulnerable elderly couple had a care package, arranged through the council, supporting them to live independently at home. This involved a deliberate pattern of calls throughout the day so the couple got the support they needed.

During the pandemic, care workers decided to change the number and length of visits to fit their own convenience rather than the couple's care needs. They also failed to provide the couple with the care they needed, and didn't wear the necessary PPE. To make matters worse the couple were charged for care they didn't receive.

The council's own investigation failed to properly consider the complaint. It took far too long and missed chances to criticise safety, as well as the important questions about overcharging.

Recommendations to improve

Following our investigation, the council agreed a detailed improvement action plan for the care provider to learn from the mistakes and stop this happening in future.

Benefits and taxation – cases about financial support for businesses affected by COVID-19

We found faults in how councils had set up grant schemes, albeit at very short notice, particularly by failing to have appeal mechanisms in place or not explaining how they had made decisions when challenged through complaints.

The stakes for individual companies were often high. While recognising the pressure councils were under to develop schemes at pace, we decided it was important, particularly when challenged, for them to justify their decisions.

We also found faults in how councils had recovered grants paid in error. Again, with such significant implications for businesses, we stressed the importance of councils doing this fairly, communicating their decisions clearly and transparently.

One case met our threshold for issuing a public interest report, in which we found significant problems with the council's council tax support repayment policy and its communications to the public.

Case reference: 20 008 374

The complainant rented a shop focused on Christmas and Easter trade. He contacted the council to ask about whether it was eligible for COVID-19 support funding. He then complained about the council's decision not to award a grant.

We found the council's complaint correspondence about its decision making was confusing. It gave different reasons at different times for the same decision. It gave different dates for when it considered the shop was open. It failed to consider relevant evidence about occupancy but considered irrelevant guidance about occupancy when making its decision.

Case reference: 20 008 553 (public interest report)

A man requested help from his council with paying council tax bills during the pandemic. This was partly because of the impact of the pandemic on his finances. The council agreed a reduced payment plan with him but, despite this, kept sending letters saying his payments were overdue.

We found the council did not give the man clear information about when the payment plan would end or that he would face recovery action irrespective of keeping to payments. It did not explain its recovery policy and acted contrary to the information it did give about stopping further reminders. It did not suggest he apply for discretionary relief despite him telling officers he was struggling to pay bills. The council had no published information about a discretionary relief policy and does not appear to have any set criteria for considering a request.

Recommendations to improve

We asked the council to publish a policy, provide training or guidance to staff about telling citizens about opportunities to apply for benefits, discounts or relief, and ensure they consider such requests in line with policies. They should also be clear about payment plans at the outset, including how and why they will end, details of any review and warning of any further recovery action

Case reference: 20 013 729

The council asked for repayment of a COVID-19 support grant it had paid to a man's car park business. He used a small part of his premises for retail. We found the council was entitled to decide it paid him by mistake. But this was entirely the council's fault.

The council had flexibility to decide, in the circumstances, whether and how to recover money. Government guidance about this mainly concerned fraud which was demonstrably not the case here. We found the council did not properly consider the man's circumstances and whether it was appropriate to recover any or all of the payment.

Recommendations to improve

The council agreed to learn wider lessons from the complaint by introducing a policy for considering repayment of COVID-19 business grants paid by mistake, taking account of our principles of good administrative practice.

Children's services – statutory complaints procedure

The way councils deal with complaints about children's services is set out in statutory guidance, and follows a three-stage process. This process, which aims to ensure thorough, independently scrutinised and rigorous investigation, was unaffected by the Coronavirus Act and other changes to legislation.

Our investigations found examples of councils wrongly suspending the statutory process during the pandemic, meaning people were denied access to this vital check on potentially flawed practice.

We have recently published a guide to learning from our investigations involving the children's services complaints procedure.

Case reference: 20 005 821

A man complained the council failed to provide his son with social care support following his discharge from psychiatric hospital in July 2019. The council took longer to deal with the complaint because of COVID-19. It failed to investigate the man's complaint under the statutory children's complaints procedure. The council's policy wrongly restricts itself to only look at complainants who are 'customers' of social services which is narrower than government guidance outlines.

Recommendations to improve

The council agreed to review its complaints policy to bring it into line with statutory guidance.

Case reference: 20 009 341

The complainants were registered foster carers with two children placed with them by the council. Following an incident, the council removed the children. They complained and the complaint started to be dealt with through the statutory children's complaints procedure. The council then suspended all stage two and three complaint investigations because of the strain caused by the pandemic.

We found that while COVID-19 had placed strain on all council services, there was no change to law or guidance about the statutory procedure and so its delay was fault, which caused injustice.

Environmental services & public protection: noise nuisance and anti-social behaviour

Successive lockdowns meant people sometimes sought help from councils to deal with neighbour noise and anti-social behaviour. In some cases, council officers were temporarily redeployed from teams normally responsible for responding to these requests.

We investigated several complaints in which we found councils at fault in keeping people sufficiently informed about what was happening, and in delivering services that were not part of the relaxation in duties during the pandemic.

Case reference: 20 010 189 (public interest report)

A woman complained about noise nuisance and waste build-up on a neighbouring property during the pandemic. She said she and her partner had suffered unbearable noise and vibrations from loud music and the waste was attracting vermin. She sent noise logs and repeatedly asked the council for updates.

We found the council did not do enough to investigate her concerns or keep her updated with progress. It had received a large increase in complaints during the pandemic while officers were affected by the need to shield and self-isolate. It had a backlog of around 200 other un-investigated noise complaints, in part caused by the introduction of a new system.

Recommendations to improve

As a result of our investigation it agreed to look into the concerns and to develop an action plan to ensure it investigates any ongoing noise complaints as soon as possible.

Housing: homelessness

We investigated a homelessness complaint where the council struggled to deal with the situation caused by the start of the pandemic and the request to review its housing allocations decision got lost.

Case reference: 20 009 360

The complainants made three reports of anti-social behaviour about noise from various neighbours over a period of several years. In one case the council was unable to provide a service for three months because of COVID-19.

We found that despite the involvement of the police, the council should have considered whether to act under its powers. There was no evidence it did so and no record of whether it decided the case had been handed over to the police. The council did not keep the complainants updated and allowed things to drift.

Recommendations to improve

During our investigation the council took action to improve its services by improving officer access to IT systems for good case management and record keeping, develop policies on service standards, training for staff, including about unconscious bias for people with mental health issues. It has also set up better coordination between anti-social behaviour and environmental protection teams to share information and good practice on joint cases.

Case reference: 20 009 245

A woman asked the council for help with her homelessness before the pandemic. She was living in a caravan on a residential site that had closed. She couldn't find an alternative. The council helped with advice about alternatives and referred her to a charity which arranged emergency accommodation under the national initiative to help homeless people during the pandemic: 'Everyone In'.

Neither the charity nor council told the woman about the cost of this, which she did not discover until mid-June. We said we would normally have expected information about costs but the council was struggling to cope at the start of the pandemic. Therefore, we decided its lack of records about whether she was advised about costs was not fault.

However, we found the council should have treated her subsequent complaint as a request for a review of its housing register decision. Its failure to do so meant the woman suffered uncertainty.

It was not clear whether or how the council considered if her living in a touring caravan without a year-round pitch should have been treated as owning a home for the purposes of its policy.

Recommendations to improve

The council agreed to remind staff to give clear information in housing register decisions about how to request a review of the decision. It will also remind them to consider whether a complaint should be treated as a request for a review of a housing decision so it can respond appropriately.

Planning enforcement

We investigated some complaints involving services that councils have considerable choice about whether or not to take action. Planning enforcement must be investigated but councils have discretion about taking subsequent action. Enforcement was therefore clearly a lower priority for many councils at the peak of the pandemic.

In one, unpublished, case we found the council failed to investigate someone's concerns about a neighbouring development during the pandemic. The council was entitled to decide action was not 'expedient' during the pandemic but should have explained this and also explained whether, when the impact of COVID had abated, it would return to the case.

Case reference: 20 013 791

During the pandemic a neighbour installed noisy equipment near the shared boundary, without seeking planning permission. The council was dealing with a backlog of potential planning enforcement breach investigations caused by the impact of the pandemic on staffing.

More than a year passed from the time the council received this complaint. We found that even though the pandemic's impact was inevitable, this delay was significant, causing injustice. During that time the man affected by noise had to keep making complaints and reports, not knowing what, if anything, was happening.

6. Seeking continuous improvement – learning from the crisis

Our expectations

This principle is about using the learning from working during a crisis to make improvements. Complaints are often a source of valuable feedback, highlighting where systems, processes and procedures need improving.

Being forced to work in different ways can spark innovation. Having challenged assumptions about what works, the option remains to consider making those changes permanent, or returning to normal practice to ensure people get the right service.

This was one reason we emphasised the importance of organisations continuing to devote adequate resources to complaint handling, even when the pressure of dealing with the pandemic was unprecedented.

This principle also recognises the impact sustained crisis working can have on organisations. Time horizons can narrow to deal with the immediate pressure. Capacity and resources normally devoted to medium and longer-term planning can be lost.

Our guide said:

- Continue to use complaints as an effective and immediate form of feedback during the crisis. Complaints can continue to tell you where new challenges are developing and where things are going wrong
- While most staff focus on short term responses to the crisis, keep a longer-term view to ensure the authority is prepared for downstream consequences and plans for recovery and normalisation
- In a time of rapid change, try to ensure you don't lose critical organisational memory. Staff used outside of their normal areas during the crisis will likely return afterwards, risking loss of critical records and memory

What we found

We are unlikely to receive complaints about organisations not following this principle.

However, where we identify faults that have caused injustice to complainants or potentially others, we make recommendations to help improve those services. These service improvements have the power to benefit many people.

By taking a proactive approach to learning from all complaints, organisations can benefit from many more examples beyond the small subsection that reach us. The link between complaint handling and service performance should be hard-wired.

Below are examples of some significant service improvements councils and care providers agreed to implement in COVID-19 investigations (some are featured in the earlier case studies). Some, we would make in non-COVID complaints. Others are a direct consequence of having to quickly adapt ways of working. All represent the opportunity to ensure learning is embedded and not needed to be relearnt.

We upload service improvement recommendations for every council to our Councils Performance Map each week

Adult social care

- (20 010 666) The care provider should ensure staff identify people approaching the end of their lives, before they are at the very end of their lives, and put appropriate plans in place
- (20 001 450) The care provider should remind staff of process for obtaining urgent, end of life medication, including alerting community nurses when medicines are in the building
- (20 004 806) The care provider should produce an action plan to ensure it gives notice for terminating contracts to the right person and reviews care packages when it has problems delivering them
- (20 004 275) The care provider needs to put staff training in place on making best interests decisions under the Mental Health Act 2005
- (20 007 059) The council will ensure officers do risk assessments and record them before visiting people in their homes and take appropriate personal, protective equipment with them to cover all possibilities
- (20 004 448) The council will identify action it needs to take to ensure it:
  - does person centred risk assessments before deciding someone's needs can be met at another care home
  - provides people with an indicative personal budget
  - responds to request for information about third party top ups for care home fees
  - avoids delay sending a care and support plan

Education and Children's Services

- (20 000 632) The council will remind staff and providers of the need to ensure preparation for adulthood is discussed at annual reviews from Year 9 onwards
- (20 005 883) The council will check it sends new and amended EHC Plans to education settings and that provision is being delivered. It will ensure annual reviews are completed on time, especially at key stages in the young person's education
- (20 005 038 and many similar others) The council will ensure education appeal panels and clerks give clear reasons for decisions recorded in the clerk's notes and are set out in the decision letter
- (20 010 974) The council will review its policies and procedures on alternative education and children missing education to ensure reminding staff about duty to arrange alternative education when children are not receiving suitable education for reasons other than illness

Support for businesses and council tax

- (20 003 011) The council will ensure that any future grant scheme gives applicants a right of review or appeal if they disagree with decisions
- (20 013 729) The council will introduce a policy for repayment of business grants paid in error, taking account of good administrative practice when considering debts caused by the council's mistake
- (20 008 332) The council will review its discretionary rate relief policy to clarify what is meant by supporting vulnerable organisations, advise officers about how they should consider alternative sources of financial support, clarify the procedure for assessing requests and explain what happens if the ratepayer is dissatisfied with the outcome

- (20 008 553) The council will publish a council tax discretionary policy on its website including an appeal process. It will train staff to inform customers of opportunities to apply for benefits, discount or relief and remind staff about giving customers clear information, including about appeals and recovery action
- (20 001 522 and many similar others) The council scrutiny committee will run a lessons learnt exercise into the use of discretionary business grants to ensure future schemes are open, transparent and consistent in application
- (20 006 486) The council will ensure staff have due regard to the public sector equality duty in decision making (the complaint involved a decision to stop setting up market stalls during the pandemic) and handle complaints in line with its policy

Noise nuisance and anti-social behaviour

- (20 010 189) The council will write to all people with live noise complaints checking if they are still experiencing problems and devise an action plan to investigate any ongoing noise complaints

Housing

- (20 004 585) The council will give staff in housing allocations and options teams refresher training, to ensure they can identify information from potential applicants that triggers various Housing Act duties
- (20 009 245) The council will remind staff to give clear information in decision letters about how to request a review, and whether complaints should be treated as a review of a housing decision so it can respond appropriately

Other

- (20 005 385) An allotment complaint about access to the allotment during lockdown revealed the council was unclear about its responsibility for these services. It agreed to review its procedures and brief allotment societies about good complaint handling and signposting to us

Questions for councillors and scrutiny committees

Locally elected councillors have the democratic mandate to scrutinise the way councils carry out their functions and hold them to account.

Although care providers do not have similar arrangements, their boards of directors or appropriate management bodies can similarly keep oversight of practice. Councils with social care responsibilities also can shape and influence their local care market through contract management.

We are pleased many organisations responded to our decisions about them by incorporating these in fundamental reviews of practice, to learn lessons from their experience of COVID-19. This has been a particularly common and welcomed response for complaints that have involved new and emerging organisational practice – for example councils delivering new grant schemes at a fast pace.

We have identified some questions and approaches that elected members, and in particular leaders and scrutiny committees, can pose about the learning points identified from the case studies in this report.

These questions are also at the heart of our own reflection on our practice during the pandemic.

1. Is there the opportunity for your organisation to run a 'lessons learnt' exercise related to its response to COVID?
2. Is there any learning from the pandemic about rapid development of new policies, for example:
    a. How are they promoted externally and to frontline staff?
    b. How is their development documented – are there reasons for key decisions, for example about prioritisation?
    c. How are they consulted on proportionately and effectively, particularly considering the needs of people with protected characteristics?
3. What lessons could be learnt around prioritising workloads – are staff appropriately empowered to make decisions about this in crisis working conditions?
4. Did the organisation get the balance right between the need for rapid, often blanket, application of new rules, and making decisions that reflect personal circumstances?
5. Were online and other rapid communication tools used consistently, quickly and accurately to give up-to-date information about eligibility, timescales and appeal rights during the crisis?
6. Did the organisation give appropriate weight to key safeguards, such as the public sector equality duty, in emergency decision making?
7. Did the organisation (where appropriate) have the right levers and ability to influence the work of key contractors and others delivering services on its behalf during the crisis? Were contracts sufficiently robust and flexible to accommodate crisis working?
8. Was the organisation able to effectively redeploy staff to ensure service delivery was maintained as far as possible? What impact did this have on the services staff were taken from and how was this managed?
9. What lessons can the organisation learn about introducing and operating business grant schemes, including offering effective review of decisions and a means of dealing with complaints?

Appendix


STAY SAFE
SHOP LOCAL
SOCIAL
DISTANCING
IN OPERATION
Keep
a safe
distance
HM Government
European Union
European Regional
Development Fund

Appendix

Further case studies

Below are some other relevant cases used to compile our findings in this report. They still only represent a snapshot of all the investigations we have completed on COVID related complaints.

You can browse and search for all our published decisions at www.lgo.org.uk/decisions and use the 'COVID-19' filter in the subject area field to narrow your search.

1. Getting it right

Adult social care

- Case reference: 20 002 828

Mrs X complained the care home failed to look after her father, Mr Y, properly, resulting in him spending time in hospital. The care home was ill-equipped to deal with the demands arising from COVID-19. It failed to meet Mr Y's needs or identify the fact he was unwell. The provider needs to apologise to Mrs X and pay financial redress to Mr Y.

- Case reference: 20 003 507

Mr X complained the care home, where the council placed his mother, Mrs Y, failed to look after her properly during the first COVID-19 lockdown before her death in May 2020. The care home's records of the care provided for Mrs Y are inadequate, which leaves doubt over whether it was meeting all her needs properly. The council should apologise to Mr X and Mr Y for the unnecessary distress this has caused them.

- Case reference: 20 006 336

Ms D complained the provider was negligent when caring for her late father at the care home. We have found fault causing injustice. The care provider should apologise to Ms D.

- Case reference: 20 007 011

Mr X complained the council failed to deal properly with him when he became homeless and failed to meet his eligible care needs. The council has apologised for the lack of communication from its Housing team. However, it has not addressed the failure to deal properly with Mr X's care needs, including a failure to meet them for several days. It needs to apologise, pay financial redress and improve its working practices.

- Case reference: 20 004 090

The council's delay in conducting an Occupation Therapy assessment of Mrs X was fault. As a result, Mr X cannot know if his wife's last weeks could have been less painful and more dignified. The council has agreed to apologise and pay Mr X £250 in recognition of this injustice.

Special Educational Needs

- Case reference: 20 000 627

Mr X complained that the council failed to ensure his son received all the support he should have had under his Education Health and Care Plan, including during the COVID-19 pandemic. We do not find the council was at fault in the way it dealt with the special education provision, but it did not record or provide enough information to Mr X about what support would be provided. It has agreed to apologise to Mr X.

- Case reference: 20 001 263

There was fault by the council in the Education, Health and Care needs assessment and planning process for Y. This fault caused Y a loss of special education provision. It also caused Mrs X, his mother, a financial loss and avoidable distress. The council will apologise and make payments described in this statement.

- Case reference: 20 000 632

We upheld Mrs X's complaint about how the council has handled her daughter Y's education, health and care provision. There was fault in the council's approach to Y's annual reviews and preparation for adulthood. The council also failed to explain what provision would be delivered when colleges closed to most learners in response to COVID-19. These faults caused an injustice to Mrs X and Y, and the council agreed to take action to remedy this.

- Case reference: 20 010 974

Mr X complained that the council did not do enough to provide suitable education for his son, D, or get him back on the school roll after he withdrew D from school to home educate him. Mr X told the council he did not want to home educate and had only withdrawn D because he did not think the school could keep him safe from the risk of COVID-19. We find that while the council made considerable efforts to try and ensure D had a school place, it should have brought matters to a head sooner. The council was at fault in failing to offer alternative education while it was trying to resolve the matter. The council has agreed a suitable remedy.

- Case reference: 20 007 260

Mrs B complained the council did not secure suitable education provision for her son and delayed reviewing his Education, Health and Care plan. Mrs B said her son missed education and EHC provision. We found fault with the council for failing to secure education and Education, Health and Care provision for C. We also found delays in the council's EHC process. The council will make a financial payment to Mrs B to remedy the injustice caused by these faults and make service improvements.

Homelessness

- Case reference: 20 000 450

Mr X complained about the standard of accommodation the council provided during the COVID-19 pandemic, and about failings in the way it handled his homelessness application. The council was at fault for a delay in responding to Mr X's concerns about the accommodation, which it later accepted fell below its standards. It was also at fault for failing to review its decision that Mr X was not in priority need. It has already apologised, made a payment of £500 and taken action to prevent recurrence so no further recommendations are needed.

- Case reference: 20 008 082

Ms X complained the council failed to deal with her homelessness case and about its poor communications with her during that time. The council was at fault when it continually failed over several months to take any action in relation to Ms X's case. The council has agreed to pay Ms X £400 to remedy the injustice it caused her. It has also agreed to provide proof of the steps it has taken to prevent a similar recurrence of the fault in future.

2. Being service-user focused

Adult social care

- Case reference: 20 000 794

Mrs X complained the care home where the council had placed her brother, Mr Y, failed to take him back when he was ready to leave hospital at the end of March 2020, resulting in him spending too long in hospital, catching COVID-19, and spending time in another care home before moving to alternative permanent accommodation. The council and the care home should not have allowed Mr Y to become the victim of their dispute over the cost of meeting his needs, which prevented him from leaving hospital when he was ready to do so.

- Case reference: 20 004 275

Mrs X complained the care provider failed to deal properly with family contact arrangements at its care home during COVID-19, resulting in a decline in Mrs Y's mental health and avoidable distress to herself. The provider has not dealt with this matter properly, resulting in avoidable distress. It needs to apologise, pay financial redress and take action to prevent similar problems from arising again.

- Case reference: 20 008 335

We upheld Mrs D's complaint about a failure to provide Mr E with care and support through his direct payment between July and November 2020. There was also fault in the council's complaint handling. The fault caused Mrs D avoidable time and trouble and a financial loss to another family member who transported Mr E to his day centre. The council will apologise, make Mrs D a symbolic payment and refund the family member their costs.

- Case reference: 20 007 918

Ms C complained about the way the council responded to her request for help and advice, when her main carer (her mother) potentially had Covid. We found fault with the way the council responded to this, which caused Ms C distress. The council has accepted this and agreed to provide an apology to Ms C, pay her a financial remedy for distress, and share the lessons learned with staff.

- Case reference: 20 008 131

Ms X complained the council failed to exercise enough flexibility over the use of direct payments during the COVID-19 pandemic. The council failed to follow government guidance on Using direct payments during the coronavirus outbreak when Ms X asked to use her son's direct payments to employ a live-in carer. This left her providing full-time care for longer than was necessary. The council has agreed to apologise and pay financial redress.

- Case reference: 20 012 222

Ms X complained about the way the council dealt with her request for a Disabled Facilities Grant. We find the council was at fault for delay in arranging the Occupational Therapy assessment. There were also faults in its communication with Ms X. The council has agreed to apologise to Ms X for frustration caused. It is already writing an action plan to address Disabled Facilities Grant wait times.

- Case reference: 20 008 745

Miss X complained the care provider handled her mother, Mrs Z, roughly during a visit. Miss X also complained the care provider banned her and her family from visiting and then gave Mrs Z notice to leave the care home without proper reasons. We cannot come to a conclusion on whether Mrs Z was handled roughly. The care provider was not at fault for how it decided to ban Miss X. It was at fault for banning the rest of the family and for giving Mrs Z notice. It has agreed to apologise to Miss X and make sure it has a process in place for dealing with difficult relationships.

- Case reference: 21 001 093

There was fault in Mrs Z's care in a care home. Staff did not act in line with COVID-19 guidance and record keeping, and communication was not in line with accepted standards. The council will apologise and take action described in this statement.

- Case reference: 20 007 431

Mrs D complained about the care provider's actions during the COVID-19 pandemic while her late mother was a resident at its care home. We have found the care provider was at fault for not facilitating an indoor end of life visit for Mrs D and her brother. This has caused significant injustice to them as they missed an opportunity to spend time with their mother before she died. The care provider has agreed to apologise to them.

- Case reference: 20 007 576

Mrs F complained on behalf of her mother that a council-funded care home failed to allow her to visit her late father when he was at the end of his life during the COVID-19 pandemic. We have found fault causing injustice. The council has agreed to apologise to Mrs F's mother.

- Case reference: 20 007 614 (joint health and social care decision)

Miss B and Mrs C complained about the care their late grandmother Mrs P received in a council-funded care home and from district nurses. Failings in Mrs P's care by the home and district nurses led to her developing severe pressure ulcers in the last weeks of her life. The council did not investigate key issues in the complaint. The organisations should apologise and make a payment to Miss B and Mrs C to acknowledge the distress they suffered. The council should also ensure the home makes service improvements.

- Case reference: 20 006 857

Ms X complained the council delayed dealing with her sister Miss Y's request to move care homes. The council was at fault. It failed to properly consider Miss Y's preferences and failed to provide any suitable alternative options to meet Miss Y's needs. It failed to acknowledge Ms X was not willing to support her sister long term. This caused Ms X and Miss Y uncertainty and frustration and placed Ms X under significant strain as she had to care for her sister far longer than she expected to. The council has agreed to apologise to Ms X and Miss Y and make a payment to recognise the impact the faults had on them. It has also agreed to progress Miss Y's move to a care home as soon as possible.

Support for businesses

- Case reference: 20 007 792

Ms D complained the council did not award her business a Retail, Hospitality and Leisure Grant to help with the impact of COVID-19. We find the council at fault as it did not properly consider statements made by Ms D in support of her request, nor consider using its discretion to pay her a grant. This caused Ms D uncertainty. The council accepts these findings and has agreed to reconsider Ms D's request for a grant.

- Case reference: 20 001 593

There was fault in how the council considered whether the complainant's music business was eligible for the expanded retail discount. It misinterpreted government guidance about tutoring, and also did not consider whether other aspects of the business meant it should be classified as 'retail'. The council has agreed to review its decision on these points and offer the complainant a financial remedy for his time and trouble.

School admissions

- Case reference: 20 001 119

Mrs Q complained an independent appeals panel had failed to properly consider her appeal for a school place for her son, R. This had caused the family significant distress. The investigation found evidence of fault and the school has agreed to hold a fresh appeal.

- Case reference: 20 004 888

There was fault in the process followed by the independent appeal panel, for admissions to Year 7 of the school in September 2020. This did not cause the complainant a personal injustice, but it may have affected other appeals. However, we consider it would be disproportionate to recommend a repeat of the appeals process for the 2020 intake, and the School has already changed its appeal process for its 2021 intake, which means the same faults should not recur.

- Case reference: 20 002 695

Miss B complained the admissions authority did not carry out her son's school placement appeal correctly and it was refused. We found fault with the admissions authority causing injustice. The admissions authority has agreed to apologise and offer a fresh appeal to remedy this injustice.

3. Being open and accountable

Adult social care

- Case reference: 20 001 041

Mr X complained the council failed to meet his son's care needs since shortly after the country went into lockdown because of COVID-19. The council was at fault for telling Mr X it would be able to reinstate his son's pre-COVID-19 respite care when that was not possible. The council needs to apologise and recognise the lack of trust this caused.

- Case reference: 20 008 020

Mr X complained the council charged him for a period of reablement care which it should not have, after he was discharged from hospital. The council accepted it did not make it clear to Mr X which care he would need to pay for and agreed to refund the care charges he disputed. We were satisfied this remedied the injustice to Mr X so we completed our investigation.

- Case reference: 20 004 448

Ms X complained the council failed to assess her father's (Mr Y's) needs properly, failed to identify an indicative personal budget or agree a final budget. The council failed to meet Mr Y's needs after his capital fell below £23,250 and failed to assess the risk to him of moving to another care home. This left him paying for his own care when the council should have been helping to fund it. It should refund Mr Y, apologise to his daughter and pay her financial recompense.

- Case reference: 20 010 261

Mrs X complained the council failed to advise her that COVID-19 NHS funding for her mother, Mrs Y's care had ended, or that it had completed an assessment of her needs. The council was at fault as it did not share a copy of the assessment with Mrs X and delayed telling her the funding had ended. This meant Mrs Y avoidably incurred care home fees. If the council had given clear, timely information she would have moved in with Mrs X sooner. The council has agreed to apologise to Mrs X and to refund some of the care fees to Mrs Y.

Homelessness

- Case reference: 20 008 716

On the basis of information seen, there was no fault in the way the council handled Mr X's temporary accommodation from late March 2020, during the COVID-19 pandemic. It was at fault for not informing him of the service charges for alternative accommodation provided in early July 2020, for which it has apologised and waived the charges. This was an appropriate remedy.

Planning

- Case references: 20 001 070 and 20 001 071

Mr B and Ms C complained about the council's handling of two planning applications. They also complained about the council's handling of their complaints about that. We find no significant injustice was caused by the handling of the first planning application, and no fault in the handling of the second planning application. We find there was fault in complaint handling, causing injustice for which the council has agreed to apologise.

- Case reference: 20 005 585

Mrs C complained the council failed to properly consider a planning application for a house built close to her home and tell her a panel meeting had been cancelled. We found no fault with the council's decision making process but did find it at fault for failing to tell Mrs C about the cancellation of the meeting. The council has agreed to apologise to Mrs C and pay her £100 for raised expectations and frustration and for putting her to the time and trouble of complaining.

4. Acting fairly and proportionately

Business support

- Case reference: 20 000 929

Mr X complained the council did not follow a proper decision making process and wrongly refused his business a grant, causing distress, financial loss and redundancies. We find fault in the council's decision making process causing uncertainty. We recommend the council provides an apology, makes a payment, reviews its decision and acts to prevent recurrence.

- Case reference: 21 000 122

Mr B complained the council misled him into thinking his business would receive a grant to support businesses impacted by COVID-19. We upheld the complaint finding the council sent Mr B a series of emails which caused confusion and uncertainty. The council accepted these findings and we set out the action it has agreed to remedy that injustice

- Case reference: 20 011 367

Mr X complained the council wrongly refused him a small business grant, causing financial difficulties for his business. We find no fault in the council's decision to refuse a grant but we find fault in its communications with Mr X. We recommend it provide an apology, time and trouble payment and take steps to prevent recurrence.

5. Putting things right

Adult social care

- Case reference: 20 007 202

Mrs F complained about council-commissioned homecare during the first COVID-19 lockdown. We have found fault which caused Mrs F distress and to miss out on care. The council has agreed to apologise to Mrs F and make her a payment to remedy this.

Children's services

- Case reference: 20 002 763

The complainant said the council had failed to start a Stage 2 investigation, under the statutory Children Act complaints procedure. This has caused avoidable frustration. We find fault causing injustice by the council. The council has now agreed to undertake a Stage 2 investigation and to apologise to the complainant.

Environmental services – anti-social behaviour

- Case reference: 20 001 614

The council made decisions about noise nuisance and anti-social behaviour without any investigation process. However, the council moved tenants to new accommodation, which resolved the issues quicker than if it had taken formal action. This removed the impact on the complainant of loud music and intimidating behaviour. The council will work closely with future tenants, has given a single point of contact for complaints about this property, and will meet the neighbouring residents once the restrictions of the COVID-19 pandemic are lifted.

- Case reference: 20 009 097

Mr X complained about the council's refusal to undertake an anti-social behaviour case review. The council failed to properly apply the local case review threshold and was responsible for delays in responding to Mr X's application. The council agreed to apologise to Mr X and review its processes.

Local Government and Social Care Ombudsman
PO Box 4771
Coventry
CV4 0EH

Phone: 0300 061 0614
Web: www.lgo.org.uk
Twitter: @LGOmbudsman