SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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SPSO Complaints Standards **www.valuingcomplaints.org.uk**

Scottish Parliament Region: Highlands and Islands
Case ref: 201811019, The Moray Council
Sector: Local Authority
Subject: Social Work / Continuing care

Summary

Ms C complained to my office on behalf of her son, Mr A, about the care and support provided to Mr A by the Council. Mr A, was a Looked After Child under Section 25 of the Children (Scotland) Act 1995 (a child who is looked after by the local authority as part of a voluntary arrangement). In September 2015, Mr A moved to a residential school placement outwith the Moray area. In June 2019, the Education component of Mr A's placement ended following his eighteenth birthday. The Council then transitioned Mr A from Children's to Adult Social Work Services. Adult Services agreed to financially support Mr A to remain in the residential placement for one year until June 2020 or until an appropriate resource was found in the Moray area.

Ms C is concerned that the Council have not fulfilled their responsibility to provide her son's residential placement under Continuing Care (the local authority's duty to provide the same accommodation and other assistance as was being provided by the local authority, immediately before the young person ceased to be looked after).

We took independent advice from a social work adviser. We found that:

- the Council failed to begin transition planning for Mr A at least 3 years before he was due to leave school;
- the Council failed to carry out a pathway assessment prior to making the decision that Continuing Care was not available to Mr A and prior to transitioning Mr A to Adult services;
- the Council did not take reasonable steps to ensure that Mr A could make informed choices. In particular:
    - there is no evidence in the records that Mr A was given concrete examples of the type of care he might be offered or that he was taken to see possible care settings;

- a recommendation made at a Looked After Child Review in January 2018 to offer Mr A independent advocacy was not actioned until over a year later.

In view of these failings, we upheld Mrs C's complaint that the Council failed to act reasonably regarding Mr A's care and support.

Ms C also complained about the Council's communication with her about her son's care and support. Following advice from a social work adviser, we found that:

- the Council largely engaged with Ms C via email rather than holding meetings outwith the formal Looked After Child Review process;
- an invite to a Looked After Child Review was sent three days before the Review was due to take place;
- there was a delay in the Look After Child Review minutes being available and there was a delay in these being sent to Ms C;
- Ms C was not provided with information on how to make a Continuing Care request when she requested this.

In light of these findings, we upheld Ms C's complaint that the Council's failed to communicate reasonably with her.

Lastly, Ms C complained about how the Council handled her complaint. We found that there was an unreasonable delay in Ms C receiving a response to her complaint and the Council's complaint response had been copied directly from an email that had been sent to Ms C before she submitted her complaint. There was no evidence that the Council had investigated Ms C's complaints, and the Council's complaint response did not address all the complaints that Ms C made to the Council or indicate whether her complaints were upheld or not upheld. In view of these significant failings, we upheld Ms C's complaint that the Council had failed to handle her complaint reasonably.

Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Council to do for Ms C and Mr A:

Rec. number	What we found	What the organisation should do	What we need to see
1.	Under complaint (a) we found that: • the Council failed to begin transition planning for Mr A at least three years before he was due to leave school. • the Council failed to carry out a pathway assessment prior to making the decision that Continuing Care was not available to Mr A and prior to transitioning Mr A to Adult Services. • the Council did not take reasonable steps to ensure that Mr A could make informed choices. In particular: o there is no evidence in the records that Mr A was given concrete examples of the type of care he might be offered or that he was taken to see possible care settings.	Apologise to Ms C and Mr A for: • failing to begin transition planning for Mr A at least three years before he was due to leave school. • failing to carry out a pathway assessment prior to making the decision that Continuing Care was not available to Mr A and prior to transitioning Mr A to Adult Services. • failing to communicate reasonably with Ms C about her son's care and support. • failing to handle her complaint reasonably. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy or record of the apology. By: 20 May 2020

Rec. number	What we found	What the organisation should do	What we need to see
	○ a recommendation made at a Looked After Child Review in January 2018 to offer Mr A independent advocacy was not actioned until over a year later. Under complaint (b) we found that the communication with Ms C was unreasonable. In particular: • the Council largely engaged with Ms C via email rather than holding meetings outwith the formal Looked After Child Review process. • an invite to a Looked After Child Review was sent three days before the Review was due to take place. • there was a delay in the Look After Child Review minutes being available and there was a delay in these being sent to Ms C. • Ms C was not provided with information on how to make a Continuing Care request when she requested this.		

Rec. number	What we found	What the organisation should do	What we need to see
	Under complaint (c) we found that: • there was an unreasonable delay in Ms C receiving a complaint response. • the Council's complaint response was copied directly from an email that had been sent to Ms C before she submitted her complaint. • there was no evidence that the Council had investigated Ms C's complaints. • the Council's complaint response did not address all the complaints that Ms C made to the Council or indicate whether her complaints were upheld or not upheld.		
2.	Under complaint (a) we found that the Council failed to act in line with their ordinary residence policy when they indicated that all out of area children have to move back to the Moray area as the basis for only providing funding for Mr A to remain in the residential placement for one year.	Consider whether it would be appropriate to fund Mr A to remain in the residential placement until he is 21 years of age or whether this could achieved through Self-Directed Support.	Evidence that the Council have considered funding Mr A's residential placement until he is 21 years of age or whether this could be achieved through Self-Directed Support, taking into

Rec. number	What we found	What the organisation should do	What we need to see
			account the findings of this investigation, discussing the matter with Ms C and providing Ms C with full reasons for any decisions reached. By: 20 May 2020

We are asking the Council to improve the way they do things:

Rec. number	What we found	Outcome needed	What we need to see
3.	Under complaint (a) we found that the Council failed to begin transition planning for Mr A at least three years before he was due to leave school.	Where a young person has significant additional support needs, transition planning should begin at least three years before a young person is due to leave school.	Evidence that the findings on these complaints have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that the Council have considered any training needs for social work staff in relation to transition planning. By: 22 October 2020

Rec. number	What we found	Outcome needed	What we need to see
4.	Under complaint (a) we found that the Council failed to carry out a pathway assessment in line with their Transition to Adult Services Policy prior to making the decision that Continuing Care was not available to Mr A.	Where a young person is approaching adulthood, a pathways assessment should also be carried out to assess throughcare and aftercare options (including an assessment of whether it is in the young person's best interests to remain in their current placement under Continuing Care rather than transitioning to Adult Services) with the input of the young person, their parents/guardians, Adult Services and any other interested agencies.	Evidence that the findings on these complaints have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that the Council have considered any training needs for social work staff in relation to pathways assessments, Continuing Care and Ordinary Residence. Evidence that the Council have reviewed their Continuing Care Procedure taking into account Mr A's case and the legislative framework. By: 22 October 2020

Rec. number	What we found	Outcome needed	What we need to see
5.	Under complaint (a) we found that the Council did not take reasonable steps to ensure that Mr A could make informed choices. In particular: • there is no evidence in the records that Mr A was given concrete examples of the type of care he might be offered or that he was taken to see possible care settings. a recommendation made at a Looked After Child Review in January 2018 to offer Mr A independent advocacy was not actioned until over a year later.	Looked After Children with complex needs should be given examples of the type of care they might be offered and be taken to see possible care settings. Where a recommendation has been made to offer a Looked After Child independent advocacy, this should be acted on timeously.	Evidence that the findings on these complaints have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that the Council have considered any training needs for social work staff in relation to making sure that Looked After Children with complex needs can make informed choices. By: 22 October 2020
6.	Under complaint (b) we found that the Council largely engaged with Ms C via email rather than holding meetings outwith the formal Looked After Child Review process.	The Council should engage in a meaningful way, including holding meetings with parents/guardians, outwith the formal Looked After Child Review process, when planning the future care for Looked After Children with complex needs.	Evidence that the findings on these complaints have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). By: 22 October 2020

Rec. number	What we found	Outcome needed	What we need to see
7.	Under complaint (b) we found that Ms C was not provided with information on how to make a Continuing Care request when she requested this.	Information on how to make a Continuing Care request should be provided to individuals when they request it.	Evidence that the findings on these complaints have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). By: 22 October 2020
8.	Under complaint (b) we found that: • an invite to a Looked After Child Review was sent three days before the Review was due to take place. • there was a delay in the Look After Child Review minutes being available and there was a delay in these being sent to Ms C.	Invites to Looked After Child Reviews should be distributed in a timely way. Minutes of Looked After Child Review should be typed up and distributed in a timely way.	Evidence that the Council have a system in place to timeously: • distribute invites to Looked After Child Reviews. • type up and distribute minutes of Looked After Child Reviews. By: 22 October 2020

We are asking the Council to **improve their complaints handling**:

Rec. number	What we found	Outcome needed	What we need to see
9.	Under complaint (c) we found that: • there was an unreasonable delay in Ms C receiving a complaint response. • the Council's complaint response was copied directly from an email that had been sent to Ms C before she submitted her complaint. • there was no evidence that the Council had investigated Ms C's complaints. • the Council's complaint response did not address all the complaints that Ms C made to the Council or indicate whether her complaints were upheld or not upheld.	The necessary systems should be in place to ensure that complaints are handled in line with the Moray Council's complaint handling procedure and the Model Complaints Handling Procedure and that all staff responsible for dealing with complaints should be aware of their responsibilities in this respect.	Evidence that the findings on these complaints have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that the Council's systems demonstrate senior level/governance responsibility for complaint handling. By: 22 October 2020

Feedback for The Moray Council

Points to note:

- I note that the Ordinary Residence Policy and Procedure on the Council's website appears to be out of date. The SPSO appear to have been provided with the most up to date copy of this policy and procedure. The Council may wish to consider updating this on their website.

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Ms C and the aggrieved is referred to as Mr A. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to my office on behalf of her son (Mr A) about the care and support provided to Mr A, the Council's communication with Ms C and how the Council handled Ms C's complaint. The complaints I have investigated are that:

(a) The Council failed to act reasonably regarding Ms C's son's care and support (*upheld*).

(b) The Council failed to communicate reasonably with Ms C about Ms C's son's care and support (*upheld).*

(c) The Council failed to handle Ms C's complaint reasonably (*upheld*).

Investigation

2. With my complaints reviewer, I have considered carefully all the information provided by Ms C and the Council. I also sought independent advice from a social worker (the adviser).

3. I have decided to issue a public report on Ms C's complaint due to the significant failings my investigation has identified in the care and support provided to Mr A and the significant personal injustice suffered by Ms C and Mr A as a result. I have also identified failings in the Council's complaint handling. In addition, I consider there may be wider learning from my investigation and report for other public bodies who handle Continuing Care requests and complaints.

4. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered. My complaints reviewer has reviewed all of the information provided during the course of the investigation. Ms C and the Council were given an opportunity to comment on a draft of this report.

Background

5. Mr A, was a Looked After Child under Section 25 of the Children (Scotland) Act 1995 (a child who is looked after by the local authority as part of a voluntary arrangement). In September 2015, Mr A moved to a residential school placement outwith the Moray area. The placement was jointly funded through the Council's Education and Social Work Services.

6. In June 2019, the Education component of Mr A's placement ended following his eighteenth birthday. The Council then transitioned Mr A from Children's to Adult Social Work Services. Adult Services agreed to support Mr A financially to remain in

the residential placement for one year until June 2020 or until an appropriate resource was found in the Moray area.

7. Ms C is concerned that the Council have not fulfilled their responsibility to provide her son's residential placement under Continuing Care (the local authority's duty to provide the same accommodation and other assistance as was being provided by the local authority, immediately before the young person ceased to be looked after) and have not communicated reasonably with her.

8. On 13 January 2019, Ms C complained to the Council. The Council responded on 26 March 2019. Ms C was dissatisfied with the Council's responses and brought her complaints to the SPSO in April 2019.

(a) The Council failed to act reasonably regarding Ms C's son's care and support

Concerns raised by Ms C

9. Ms C is concerned that:

- the Council have not fulfilled their responsibility to provide Mr A's residential placement under Continuing Care, the Council did not consider Ms C's request for Continuing Care and Mr A was not offered Continuing Care or able to exercise his rights.

- the Council restricted eligibility for Continuing Care to only those who can move on to live independently. Ms C is of the view that this is against the Continuing Care guidance.

- the Council made the decision to move Mr A out of Children's Services and into the Adult Services with a one-year extension to his current placement.

- an assessment was not undertaken with Ms C and her son to understand his needs and discuss his options under the Getting it Right for Every Child (GIRFEC) principles (the Scottish Government's approach to supporting children and young people. A framework to allow organisations who work on behalf of the country's children and their families to provide a consistent, supportive approach for all). Ms C is concerned that an adult assessment was undertaken instead. Ms C is of the view that an assessment should have been undertaken using the GIRFEC national practice model and SHANARRI indicators (whether a child is Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included).

- information was not presented to Mr A in a way he could understand.

The Moray Council's position

10. The Council said that Continuing Care legislation is for those young people who are moving through to independence and do not meet the criteria for ongoing Adult Services (Community Care), but do require some additional assistance to move to independence.

11. In response to my enquiries, the Council also said that:

- Mr A is eligible for Continuing Care in terms of the legislation. However, the Council indicated Continuing Care was primarily intended to meet the needs of young people leaving care by extending the period in which they can stay in care until they are ready to leave;

- Continuing Care relates to being entitled to remain in the same accommodation as was being provided by the authority until the person ceased to be looked after. The Council said that their view is that Continuing Care is not available to Mr A as the arrangements in place for his education placement have come to an end in terms of Section 26A(8)(c) of the Children (Scotland) Act 1995 Act;

- the Council's Continuing Care Policy does not specifically mention the situation where people are eligible for Continuing Care but not accessing this, because they would require ongoing care and support throughout their adulthood;

- an assessment had been undertaken under GIRFEC principles, as the Looked After Review paperwork evidences. The Council also said the assessment prepared by Adult Services to support Mr A's transition from Children's Services was informed by reports for being a Looked After Child. The Council said the assessment clearly considers Mr A's welfare needs;

- information was presented to Mr A in a written format and independent advocacy was made available to ensure that there was an understanding of Mr A's wishes.

Relevant legislation

12. Section 26A of the Children (Scotland) Act 1995 sets out the local authority's duty to provide Continuing Care (the same accommodation and other assistance as was being provided by the local authority, immediately before the young person ceased to be looked after) to an "eligible person" (a young person born after 1 April 1999 and who is at least aged sixteen but has not reached the higher age (as specified by Ministerial Orders) and whose final 'looked after' placement was in foster, kinship or residential care).

Advice

Continuing care

13. I directed the Adviser to Ms C's concerns about Continuing Care. The Adviser noted that the Council's Children and Young People's Committee report of October 2017 states:

> *"The provision of support and the continuation of a care placement is to provide a bridge from the protected status of a looked after child to adult independence. The duty does not apply to young people who are placed in Residential Schools on the basis of educational placement request, young people in secure accommodation or young people who are looked after at home. The duty applies to young people who are looked after, at least 16 years old and who have a date of birth after 1 April 1999 but have not reached the higher age specified in orders, currently 19 years."*

14. The Adviser said that the Council is correct in its assertion that when the legislation was originally envisaged it was with the intention of providing continuity to young people who were moving from care to independence. However, crucially, the Adviser noted that the legislation does not state this. The Adviser noted from the records that the Council's senior solicitor confirmed that Mr A was eligible for Continuing Care in advice given on 21 March 2019 and 26 April 2019. The Adviser said that the senior solicitor also pointed out that the Council's systems for Adult and Children's Services have not been matched up. The Adviser stated that the records suggest confusion about the status of Mr A's residential placement. The Adviser said if it had solely been an education placement it would be terminated at the age of 18. However, the Adviser said that as the placement was jointly funded by social work, the matter was not so straightforward.

15. The Adviser disagreed with the Council's position that Continuing Care was not available to Mr A because the arrangements put in place for the education placement had come to an end. The Adviser said this position does not acknowledge that the placement was jointly funded and that the social work funding did not come to an end.

16. The Adviser referred me to the Children (Scotland) Act 1995 and the Regulation of Care (Scotland) Act 2001 which require the authority to carry out a pathway assessment for each young person. The Adviser also noted that the Council's own Transition to Adult Services Policy states "in the case of those with significant additional support needs…the process of transition planning should be ongoing but begin at least three years before the young person intends to leave school". The

Adviser found no evidence that a pathway assessment had been carried out and/or discussed in a timely way with Ms C or her son. The Adviser stated that had this happened, it is likely, in view of the various recommendations in the Looked After Children (LAC) review minutes, that the pathway assessment would have concluded that it was in Mr A's best interests to remain in the residential placement for an appropriate period and that a further assessment should have taken place in conjunction with the residential placement as to the appropriateness of their care provision for a young person up to the age of 21.

17. In particular, I note that LAC review minutes for the meetings that took place on 24 January 2018 and 14 September 2018 recommended that Mr A remain at the residential placement.

18. The Adviser also said that a pathways assessment could have considered throughcare and aftercare options (including Continuing Care). The Adviser stated that if, following a pathways assessment, Continuing Care was not considered to be appropriate, then the reasons for this should be explained at an early stage and the options available should be explored with the family.

19. The Adviser noted that Children's Services also appeared to be of the view that staying at the residential placement for longer than a year would be detrimental to Mr A's welfare because the people around him would be younger and he would not be in education. The Adviser said it did not appear that this view was evidenced by any exploration with the residential placement. The Adviser noted that the residential placement provider offers placements to young adults aged 16-25. The Adviser said that although Mr A might move to a different project within the residential placement, the school, staff and surroundings would all be familiar to him and it is likely that the cohort of residents would also be familiar to him.

20. Due to the complexity of Mr A's needs, the Adviser said that a pathways assessment should have been started at an early stage and built on through discussions with Mr A, his parents and other interested agencies such as the residential placement provider and Adult Care services so that planning for his needs was undertaken in partnership with all concerned. The Adviser considered it was unreasonable that the Council did not plan for Mr A's future by carrying out a pathways assessments in a structured and strategic manner.

21. The Adviser also considered it was unreasonable that the Council did not take into account the advice obtained from their senior solicitor. The Adviser said that the Council's Adult and Child Care Policies must be coordinated to ensure a seamless journey and the Council should have at least considered and assessed whether it would be in Mr A's best interests to remain in residential placement under Continuing

Care. Given that the Council's senior solicitor considered Mr A was eligible for Continuing Care and his residential placement had been jointly funded by education and social work, the Adviser considered it was unreasonable for the Council to insist on a move to Adult Care services.

22. The Adviser said that if the Council had planned appropriately for Mr A and ensured that the appropriate assessments were carried out timeously for his needs in both the short and long term then Ms C may have had the confidence of knowing what to expect. The Adviser said there could have been a discussion that the residential placement would be suitable until a certain date and set out the specific reasons it would not be suitable beyond that date.

23. The Adviser noted that Mr A remains in the residential placement but the funding now comes from Adult Services rather than Children's Services. The Adviser said that if a pathways assessment had been carried out it may have agreed that it was in Mr A's best interest to remain there until the age of 21 under Continuing Care, and both he and his family would have been spared considerable anxiety regarding the planning for the next stage in his life.

24. As detailed above, the Adviser stated that the Council are correct in their statement that the Continuing Care legislation was not originally intended for young people who would not be able to move to independent living. In light of this, the Adviser said it was reasonable that the Council's Continuing Care Procedure did not initially cover this scenario because the policy was in place prior to the senior solicitor providing advice. However, the Adviser considered that once the problem became apparent, they should have acted to ensure that Mr A was not disadvantaged by the discrepancy. The Adviser said if the Council's Procedure makes it clear that, where a young person with complex needs will not be able to live independently, there has to be a plan discussed and agreed at least three years before the young person leaves school then that would be reasonable.

<u>Assessment by Adult Services</u>

25. I directed the Adviser to Ms C's concern that an assessment was carried out by Adult Services. The Adviser noted that an Adult Social Work Assessment was completed in or around June 2018. The Adviser considered that this assessment is well prepared and covers all the essential elements required to identify what future resources would be required. The Adviser explained the assessment shows that the residential placement were meeting Mr A's needs but it does not comment on whether they can continue to meet them in the future and until when. The Adviser said that, while the assessment is thorough regarding Mr A's needs, it does not explore the limitations, if any, of his current placement as he matures. The Adviser

also noted that it does not indicate what a future placement would look like; it only details the support Mr A would require. The Adviser considered that it was reasonable for the Council to undertake an Adult social work assessment. However, the Adviser said that this assessment did not go far enough regarding the plans for Mr A's future. As detailed above, the Adviser said that if a pathways assessment had taken place under the SHANARRI principles at an appropriate time, then steps could have been taken to reassure Ms C and her son that proactive steps were being taken to ensure his needs would be met in good time.

How information was presented to Mr A

26. I directed the Adviser to Ms C's concern that information was not presented to her son in a way he could understand. The Adviser said it is not reasonable to expect a young person with additional needs to comprehend and choose between a placement that they are in and one which may be procured, with no explanation of what, how or when. Given Mr A's complex needs, the Adviser considered he needed concrete examples and to be physically taken to see possible models for the type of care he might be offered. The Adviser said it did not appear that either of these things had happened.

27. The minutes of the LAC review held on 24 January 2018 set out a recommendation for Independent Advocacy to be offered to Mr A. This recommendation was still outstanding at the next LAC review on 14 September 2018. I also noted that an Independent Advocacy worker had an introductory meeting with Mr A on 14 March 2019. I asked the Adviser whether or not this was reasonable. The Adviser said that although the recommendation was made in January 2018 to offer Mr A advocacy, this was not actioned until over a year later. The Adviser considered that the decision was not actioned because the minute of the LAC review was not available until 5 November 2018. In the circumstances, the Adviser did not consider that reasonable steps had been taken to ensure Mr A could make informed choices.

The one-year extension to Mr A's current placement

28. I directed the Adviser to Ms C's concern that the Council made the decision to move Mr A out of Children's Services into the Adult Services with a one-year extension to his current placement. The Adviser noted that the Council did not have any appropriate accommodation in the Moray area to move Mr A to. In the Council's complaint response of 26 March 2019, they said that Mr A could choose to remain at the residential placement, rather than move back to Moray, where he will become an Ordinary Resident of the local authority where the residential placement is located (where an individual is 'ordinarily resident' determines which local authority is

required to meet their eligible care and support needs). The Council stated this would require funding to be paid independently or secured through the other local authority, as Mr A will be a resident in their area. The Adviser noted that the Council's reading of their Ordinary Residence Policy and Procedure is that if Ms C wanted Mr A to remain at the residential placement after 2020, she would either have to fund it herself or get the other local authority to accept Mr A as an Ordinary Resident. The Adviser did not agree with the Council's interpretation of matters. The Adviser noted that:

- the Transition to Adult Services Policy states that:

  "for young people in residential placements, the presumption is always that the young person will return to Moray at the end of the placement, unless they choose to remain in the placement area…Ordinary residency should be considered for each individual case"

- Section 8.3 of the Ordinary Residence Policy and Procedure states:

  "If Moray Council places someone in residential accommodation outside Moray, contracts with the placement for a service for that person and funds it…that service user remains ordinarily resident in Moray unless or until there is a break in the funding."

29. The Adviser considered that the Council did not appear to have taken into account that Mr A's placement was a joint social work/education placement and that the social work side of his living accommodation does not appear to have the same requirement to return the placement to Moray. The Adviser said that unless the Council deliberately break the social work funding, Mr A would remain an Ordinary Resident of Moray.

30. The Adviser considered that allowing Mr A to remain at the residential placement was reasonable but the rationale for only providing him with funding for one year appears to be flawed. In particular, the Adviser said it was unreasonable for the Council to indicate that out-of-area children have to move back to the Moray area.

31. The Adviser stated that Mr A has now left Children's Services and the clock cannot be put back. However, the Adviser said that the Council could still agree to fund the residential placement until Mr A is 21 years of age if it could be evidenced that this remains an appropriate placement. The Adviser said that if an alternative more appropriate placement becomes available, then this must be shown to Mr A at the earliest opportunity so he can make an informed choice. Alternatively, the Adviser said if Ms C wanted Mr A to remain at the residential placement after 2020,

she could apply for Self-Directed Support (SDS, a budget that allows people, their carers and their families to make informed choices on what their support looks like and how it is delivered, making it possible to meet agreed personal outcomes) and if an assessment agreed that Mr A's needs were best met by a facility like the residential placement then the funds could be made available to Ms C to pay the service directly. The Adviser said if a pathways assessment had been carried out then this may have been clearer.

(a) Decision

Assessment in or around June 2018

32. I accept the Adviser's comments that it was reasonable for Adult Services to undertake an assessment in or around June 2018. I also accept the advice that it was unreasonable that a pathways assessment was not carried out by Children's Services at an earlier stage which could have explored the throughcare and aftercare options for Mr A (including an assessment of whether it was in Mr A's best interests to remain at the residential placement under Continuing Care rather than transitioning to Adult Services). This would have provided an opportunity for input from Mr A, his parents and other interested agencies such as the resident placement provider and Adult Care services.

33. I note from the Council's Transition to Adult Services Policy that transition planning for young people with significant additional support needs should begin at least three years before the young person intends to leave school. If a pathways assessment had been carried out at the appropriate time this could have spared Mr A and his family considerable anxiety regarding the planning for the next stage in his life. I am concerned that this did not occur and as a result Ms C, Mr A and others were denied the opportunity to have input into his ongoing care needs. I consider this was a significant failing.

Continuing Care

34. Turning to the Council's position in relation to the availability of Continuing Care in Mr A's case. I note the Council's position that Mr A was eligible for Continuing Care in terms of the legislation but that Continuing Care was not available to him because the arrangements in place for his education placement had come to an end. Ultimately any dispute over the interpretation of legislation can only be determined by the Courts. However, the advice I have received and accept is that the Council's position does not acknowledge that the placement was jointly funded and that the social work funding did not come to an end. As detailed above, I accept the advice that if a pathways assessment had been carried out, it may have agreed that it was in

Mr A's best interest to remain in the residential placement until the age of 21 under Continuing Care. I consider it to be a significant failing that the Council did not undertake a pathway assessment prior to making the decision that Continuing Care was not available to Mr A.

Ordinary Residence

35. The advice I have received and accept is that:

- given that it appears Mr A's residential placement had been jointly funded by education and social work services, it was unreasonable for the Council to insist on a move to Adult Care services.

- under the Council's policy, it was unreasonable for the Council to indicate that out-of-area children have to move back to the Moray area and therefore the rational for only providing Mr A with funding to remain at the residential placement for one year was flawed.

36. In light of the above, I am of the view that the Council's complaint response of 26 March 2019 unreasonably advised Ms C that Mr A would become an Ordinary Resident of an area outwith Moray if he chose to remain in the residential placement after June 2020.

37. I accept the advice that the Council did not take reasonable steps to ensure that Mr A could make informed choices. In particular:

- there is no evidence in the records that Mr A was given concrete examples of the type of care he might be offered or that he was taken to see possible care settings.

- a recommendation made in January 2018 to offer Mr A independent advocacy was not actioned until over a year later.

38. Having considered all the evidence and advice carefully and for the reasons outlined above, I uphold this complaint.

39. I accept the advice that Mr A has now left Children's Services and the clock cannot be put back. Mr A is now under the care of Adult Services and it would not be possible to place him back under the care of Children's Services. In light of this I have not made a recommendation for the Council to reconsider Ms C's request for Continuing Care or for the Council to put a hold on transferring Mr A to Adult Services. I have, however, made a recommendation for the Council to consider the Adviser's comments about funding Mr A's placement at the residential placement until he is 21 years of age or whether this could be achieved through SDS.

40. You will find all my recommendations for the Council at the end of this report.

(b) The Council failed to communicate reasonably with Ms C about her son's care and support.

Concerns raised by Ms C

41. Ms C is concerned:

- that the Council have not communicated with her reasonably about the options available to her son. Ms C is concerned that clear, consistent and timely information has not been available to her.
- that she was given different reasons as to why her son did not qualify for Continuing Care.
- that she was not provided with a copy of the Council's Continuing Care policy in a timely way and information on how to make a Continuing Care request.
- about the delay in the availability of LAC review minutes.
- that as a result of information not being available to them in a timely way they have not been allowed to be properly involved in accordance with GIRFEC.

The Moray Council's position

42. As both parties to the complaint have a copy of the Council's complaint response of 26 March 2019, I do not intend to repeat the content of that response here.

43. In response to my enquiries, the Council said that there had been ongoing and regular communication between Ms C and the Council regarding Mr A's care, although it had not necessarily provided the answers to the queries Ms C had sought.

Advice

44. I directed the Adviser to Ms C's concern about the Council's communication regarding the options available to her son. The Adviser noted that the Council mostly communicated with Ms C by email and that her concerns could have been dealt with more satisfactorily by engaging with Ms C face-to-face outwith the LAC review setting. The Adviser said that given that Mr A is a young person with very complex needs, it was inappropriate to rely on email communication and LAC review meetings to discuss future plans for Mr A. The Adviser considered that face-to-face meetings which are timeously recorded should be the norm when planning the future care for young people like Mr A.

45. I directed the Adviser to Ms C's concern about the delay in the availability of LAC review minutes. In particular, that the minutes of the LAC review held on 24 January 2018 were not completed until 5 November 2018. Also that the minutes of the LAC review held on 14 September 2018 state that the minutes of the LAC review held on 24 January 2018 were not available. On 25 January 2019, the Council emailed Ms C to confirm that they had asked for the outstanding LAC review minutes to be sent to her.

46. I have seen an internal email sent within the Council on 20 March 2019 which states that there had been some confusion with the Chair of the LAC review because the last minutes were not available and they were not clear regarding transition planning.

47. I note that Ms C emailed the Council on 2 February 2019 confirming that on 29 January 2019 she had received the minutes of the LAC reviews held in December 2016 and January 2018. Ms C also raised a number of concerns regarding the minutes, including what had been said and when.

48. The Adviser said that although the minutes of the LAC review held on 24 January 2018 were completed on 5 November 2018, these do not appear to have been sent to Ms C until 29 January 2019. The Adviser said that the delay in the minutes being available was unreasonable and resulted in confusion regarding different memories and interpretations of what had been said. The Adviser stated that due to minutes not being available to Ms C within a reasonable amount of time, this resulted in her not being able to ensure her views were heard and taken into consideration.

49. The Adviser noted that the invitation for the LAC review on 14 September 2018 was sent on 11 September 2018 and as a result of this the Head Teacher of the residential placement provider did not receive it until after the LAC review had taken place. The Adviser said this did not reflect good communication.

50. Overall, the Adviser did not consider that the Council communicated reasonably with Ms C. The Adviser considered that Mr A's family should have been involved in face-to-face discussions outwith the formal LAC review process and the Council should ensure they have a system in place to record and distribute invites and minutes to LAC reviews in good time.

(b) Decision

51. I have outlined the advice I have received above. I accept the advice that the Council did not communicate reasonably with Ms C about her son's care and support. In particular, I note the Adviser's comments that:

- the Council largely engaged with Ms C via email and it may have been possible to deal with Ms C's concerns more satisfactorily by meeting with her outwith the formal LAC review process.

- there was a delay in the LAC review minutes being available and there was also a delay in these being sent to Ms C.

- an invitation to an LAC review was sent only three days before the review was due to take place.

52. I have considered carefully Ms C's concern that she was given different reasons as to why her son did not qualify for Continuing Care. I have not seen evidence that Ms C was given conflicting reasons for why Mr A did not qualify for Continuing Care. It appears that the Council have consistently advised that it was because Mr A would not be able to live independently.

53. I have considered Ms C's concern that she was not provided with a copy of the Council's Continuing Care Procedure in a timely way and information on how to make a Continuing Care request. From the records I note that Ms C emailed the Council on 2 December 2018. In this email Ms C requested any information regarding the process to request Continuing Care. I have not seen evidence that Ms C was provided with this information. I consider it was unreasonable that Ms C was not provided with this information when she requested it.

54. Having considered all the evidence and advice carefully and for the reasons outlined above, I uphold this complaint.

(c) The Council failed to handle Ms C's complaint reasonably

Concerns raised by Ms C

55. Ms C is concerned:

- about the length of time taken to respond to the complaint and that there was a lack of contact from the Council about the complaint.

- that the Council's response was copied from an email that had been drafted before Ms C submitted her complaint.

- that the Council did not confirm if their complaint had been upheld or not.
- that the Council did not look into the complaint in detail and did not provide a response to Ms C's 15 points of complaint.
- that the Council's response contains a typo of Mr A's name.

The Moray Council's position

56. In response to my enquiries, the Council acknowledged that there had been unacceptable delays in handling Ms C's complaint throughout the process. The Council explained that a range of factors contributed to this, such as staff illness, staffing changes and the sensitivities around Ms C's employment position. The Council also stated that Ms C was not kept updated or provided with a revised timescale for when she could expect a response.

57. The Council also acknowledged that:

- not every point raised by Ms C was responded to.
- their response did not confirm if the complaint had been upheld or not.
- there was an unacceptable mistake in the typing of Mr A's name.

The Council confirmed that the Acting Head of Children's Services, who drafted the response to Ms C's complaint, has now left the Council. However, the Council said that the Complaints Officer will meet with the two new Heads of Service and discuss the failures in the handling of this complaint.

Relevant policies and procedures

58. When the Council respond to complaints about service delivery they should be following the Council's Complaints Policy and the Social Work Model Complaints Handling Procedure (MCHP). These state that:

- wherever possible, a response to complaints should be issued within 20 working days following the date of receiving the complaint.
- if there are clear and justifiable reasons for extending the timeline, senior management should agree an extension and set time limits on any extended investigation. The customer must be kept updated on the reason for the delay and give them a revised timescale for completion.
- the complaint response must address all the areas that the Council are responsible for and explain the reasons for their decision.

(c) Decision

59. I have carefully considered whether the Council's complaint response addressed all the issues that Ms C raised. I note that the Acting Head of Children's Services emailed Ms C on 25 January 2019 to confirm the Council's position regarding her son. Ms C contacted the Council on 2 February 2019 to express her dissatisfaction with that email and to highlight a number of typos (including that Mr A's name had been misspelled). The Council's complaint response of 26 March 2019 was signed by the Chief Executive. The content of the complaint response appears to have been copied directly from the email sent to Ms C by the Acting Head of Children's Services on 25 January 2019. I have not seen any evidence that the Council investigated Ms C's complaints, addressed points 1-15 that Ms C raised in her complaint of 13 January 2019 or the points that Ms C made in her email of 2 February 2019.

60. I also note that Mr A's name was misspelled in both the email of 25 January 2019 and in the complaint response of 26 March 2019 and there was no indication as to whether Ms C's complaints had been upheld or not upheld. I consider these are significant complaint handling failings. They are unreasonable and contrary to the Council's Complaints Policy and the MCHP.

61. I have also considered the length of time that the Council took to respond to Ms C's complaint and their communication with Ms C during the complaints process. Ms C complained to the Council on 13 January 2019 and the Council responded to the complaint on 26 March 2019. Ideally, the Council should have provided Ms C with a response within 20 working days of receiving the complaint; by 11 February 2019. The Council acknowledged Ms C's complaint on 17 January 2019 and indicated they would be able to respond by 20 February 2019. I have seen evidence that the Council wrote to Ms C again on 27 February 2019 to apologise for the delay in responding and provided a revised timescale of 26 March 2019.

62. I can see that Ms C was kept updated on when she could expect a response, and that given the complexity of the issues, had an appropriate investigation been carried out, it may have been reasonable to extend the 20 day timescale. However, I remain of the view that the delay in responding to Ms C's complaint was unreasonable in light of the fact that the complaint response was copied directly from an email that the Council had already sent to Ms C on 25 January 2019 and given the lack of evidence of an acceptable investigation.

63. I note that the Council have said that the Complaints Officer intends to meet with Heads of Service to discuss the complaint handling failures in Ms C's case. While this is to be welcomed, poor complaint handling can have a wider impact in

that it can undermine trust and confidence in public services. I have asked the Council for evidence of the action they say they have taken in my recommendations set out at the end of this report.

64. Having considered all the evidence carefully and for the reasons outlined above, I uphold this complaint.

65. The Council have accepted the recommendations and will act on them accordingly. We will follow up on these recommendations. The Council are asked to inform us of the steps that have been taken to implement these recommendations by the dates specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Council to do for Ms C and Mr A:

Rec. number	What we found	What the organisation should do	What we need to see
10.	Under complaint (a) we found that: • the Council failed to begin transition planning for Mr A at least three years before he was due to leave school. • the Council failed to carry out a pathway assessment prior to making the decision that Continuing Care was not available to Mr A and prior to transitioning Mr A to Adult Services. • the Council did not take reasonable steps to ensure that Mr A could make informed choices. In particular:	Apologise to Ms C and Mr A for: • failing to begin transition planning for Mr A at least three years before he was due to leave school. • failing to carry out a pathway assessment prior to making the decision that Continuing Care was not available to Mr A and prior to transitioning Mr A to Adult Services. • failing to communicate reasonably with Ms C about her son's care and support.	A copy or record of the apology. By: 20 May 2020

Rec. number	What we found	What the organisation should do	What we need to see
	○ there is no evidence in the records that Mr A was given concrete examples of the type of care he might be offered or that he was taken to see possible care settings. ○ a recommendation made at a Looked After Child Review in January 2018 to offer Mr A independent advocacy was not actioned until over a year later. Under complaint (b) we found that the communication with Ms C was unreasonable. In particular: • the Council largely engaged with Ms C via email rather than holding meetings outwith the formal Looked After Child Review process. • an invite to a Looked After Child Review was sent three days before the Review was due to take place. • there was a delay in the Look After Child Review minutes being available	• failing to handle her complaint reasonably. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	

Rec. number	What we found	What the organisation should do	What we need to see
	and there was a delay in these being sent to Ms C. • Ms C was not provided with information on how to make a Continuing Care request when she requested this. Under complaint (c) we found that: • there was an unreasonable delay in Ms C receiving a complaint response. • the Council's complaint response was copied directly from an email that had been sent to Ms C before she submitted her complaint. • there was no evidence that the Council had investigated Ms C's complaints. • the Council's complaint response did not address all the complaints that Ms C made to the Council or indicate whether her complaints were upheld or not upheld.		

Rec. number	What we found	What the organisation should do	What we need to see
11.	Under complaint (a) we found that the Council failed to act in line with their ordinary residence policy when they indicated that all out of area children have to move back to the Moray area as the basis for only providing funding for Mr A to remain in the residential placement for one year.	Consider whether it would be appropriate to fund Mr A to remain in the residential placement until he is 21 years of age or whether this could achieved through Self-Directed Support.	Evidence that the Council have considered funding Mr A's residential placement until he is 21 years of age or whether this could be achieved through Self-Directed Support, taking into account the findings of this investigation, discussing the matter with Ms C and providing Ms C with full reasons for any decisions reached. By: 20 May 2020

We are asking the Council to improve the way they do things:

Rec. number	What we found	Outcome needed	What we need to see
12.	Under complaint (a) we found that the Council failed to begin transition planning for Mr A at least three years before he was due to leave school.	Where a young person has significant additional support needs, transition planning should begin at least three years before a young person is due to leave school.	Evidence that the findings on these complaints have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that the Council have considered any training needs for social work staff in relation to transition planning. By: 22 October 2020

Rec. number	What we found	Outcome needed	What we need to see
13.	Under complaint (a) we found that the Council failed to carry out a pathway assessment in line with their Transition to Adult Services Policy prior to making the decision that Continuing Care was not available to Mr A.	Where a young person is approaching adulthood, a pathways assessment should also be carried out to assess throughcare and aftercare options (including an assessment of whether it is in the young person's best interests to remain in their current placement under Continuing Care rather than transitioning to Adult Services) with the input of the young person, their parents/guardians, Adult Services and any other interested agencies.	Evidence that the findings on these complaints have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that the Council have considered any training needs for social work staff in relation to pathways assessments, Continuing Care and Ordinary Residence. Evidence that the Council have reviewed their Continuing Care Procedure taking into account Mr A's case and the legislative framework. By: 22 October 2020

Rec. number	What we found	Outcome needed	What we need to see
14.	Under complaint (a) we found that the Council did not take reasonable steps to ensure that Mr A could make informed choices. In particular: • there is no evidence in the records that Mr A was given concrete examples of the type of care he might be offered or that he was taken to see possible care settings. a recommendation made at a Looked After Child Review in January 2018 to offer Mr A independent advocacy was not actioned until over a year later.	Looked After Children with complex needs should be given examples of the type of care they might be offered and be taken to see possible care settings. Where a recommendation has been made to offer a Looked After Child independent advocacy, this should be acted on timeously.	Evidence that the findings on these complaints have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that the Council have considered any training needs for social work staff in relation to making sure that Looked After Children with complex needs can make informed choices. By: 22 October 2020
15.	Under complaint (b) we found that the Council largely engaged with Ms C via email rather than holding meetings outwith the formal Looked After Child Review process.	The Council should engage in a meaningful way, including holding meetings with parents/guardians, outwith the formal Looked After Child Review process, when planning the future care for Looked After Children with complex needs.	Evidence that the findings on these complaints have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). By: 22 October 2020

Rec. number	What we found	Outcome needed	What we need to see
16.	Under complaint (b) we found that Ms C was not provided with information on how to make a Continuing Care request when she requested this.	Information on how to make a Continuing Care request should be provided to individuals when they request it.	Evidence that the findings on these complaints have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). By: 22 October 2020
17.	Under complaint (b) we found that: • an invite to a Looked After Child Review was sent three days before the Review was due to take place. • there was a delay in the Look After Child Review minutes being available and there was a delay in these being sent to Ms C.	Invites to Looked After Child Reviews should be distributed in a timely way. Minutes of Looked After Child Review should be typed up and distributed in a timely way.	Evidence that the Council have a system in place to timeously: • distribute invites to Looked After Child Reviews. • type up and distribute minutes of Looked After Child Reviews. By: 22 October 2020

We are asking the Council to **improve their complaints handling**:

Rec. number	What we found	Outcome needed	What we need to see
18.	Under complaint (c) we found that: • there was an unreasonable delay in Ms C receiving a complaint response. • the Council's complaint response was copied directly from an email that had been sent to Ms C before she submitted her complaint. • there was no evidence that the Council had investigated Ms C's complaints. • the Council's complaint response did not address all the complaints that Ms C made to the Council or indicate whether her complaints were upheld or not upheld.	The necessary systems should be in place to ensure that complaints are handled in line with the Moray Council's complaint handling procedure and the Model Complaints Handling Procedure and that all staff responsible for dealing with complaints should be aware of their responsibilities in this respect.	Evidence that the findings on these complaints have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that the Council's systems demonstrate senior level/governance responsibility for complaint handling. By: 22 October 2020

Feedback for the Moray Council

Points to note:

- I note that the Ordinary Residence Policy and Procedure on the Council's website appears to be out of date. The SPSO appear to have been provided with the most up to date copy of this policy and procedure. The Council may wish to consider updating this on their website.

Terms used in the report

Annex 1

Continuing Care	the local authority's duty to provide the same accommodation and other assistance as was being provided by the local authority, immediately before the young person ceased to be looked after.
Getting it Right for Every Child (GIRFEC)	the Scottish Government's approach to supporting children and young people. It is intended as a framework that will allow organisations who work on behalf of the country's children and their families to provide a consistent, supportive approach for all.
Looked After Child (LAC)	a child who is in the care of their local authority (either on a voluntary or involuntary basis).
Ms C	the complainant and mother of Mr A.
Mr A	the aggrieved.
Ordinary Residence	where an individual is 'ordinarily resident' determines which local authority is required to meet their eligible care and support needs.
Self-Directed Support (SDS)	a budget allows people, their carers and their families to make informed choices on what their support looks like and how it is delivered, making it possible to meet agreed personal outcomes.
SHANARRI	part of the Getting it Right for Every Child approach. Used to assess the wellbeing of a child at any given time, parents and teachers can compare the child's experience against eight wellbeing indicators represented by the SHANARRI acronym. SHANARRI asks whether a child

	is Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included.
the Adviser	an independent social work adviser.

List of legislation and policies considered **Annex 2**

Children (Scotland) Act 1995

Continuing Care Policy (the Moray Council's own policy)

Complaints Policy(the Moray Council's own policy)

Getting it Right for Every Child (GIRFEC)

Ordinary Residence Policy and Procedure (the Moray Council's own policy)

Social Work Model Complaints Handling Procedure (MCHP)

Transition to Adult Services Policy (the Moray Council's own policy)