Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against City of York Council (reference number: 17 006 785)

16 October 2018

The Ombudsman's role

For 40 years the Ombudsman has independently and impartially investigated complaints. We effectively resolve disputes about councils and other bodies in our jurisdiction by recommending redress which is proportionate, appropriate and reasonable based on all the facts of the complaint. Our service is free of charge.

Each case which comes to the Ombudsman is different and we take the individual needs and circumstances of the person complaining to us into account when we make recommendations to remedy injustice caused by fault.

We have no legal power to force councils to follow our recommendations, but they almost always do. Some of the things we might ask a council to do are:

- apologise
- pay a financial remedy
- improve its procedures so similar problems don't happen again.

Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

Key to names used

Ms X	The complainant
Mr Y	The complainant
Z	Their youngest son

Report summary

Children's Services - Child protection

Ms X and Mr Y complain about what happened when their youngest son, who we shall call Z, was admitted to hospital. Ms X and Mr Y's son passed away whilst he was in hospital and whilst the family were subject to ongoing court action by the Council regarding their children. Ms X and Mr Y say the Council restricted their ability to spend time with Z when he was in hospital which limited the time they were able to spend with him before he passed away. Ms X and Mr Y complain the Council delayed dealing with their complaint under the statutory children's complaints procedure.

Finding

Fault found causing injustice and recommendations made.

Recommendations

To remedy the injustice caused, we recommend the Council:

- write to Ms X and Mr Y to apologise for the failure to review supervision arrangements for Z and the fact this meant they lost out on spending time with their son. The Council should also apologise for the delays in dealing with Ms X and Mr Y's complaint and for misleading them in relation to the reasons for those delays; and
- pay Ms X and Mr Y £2000 for the distress caused as a result of the failure to properly review supervision arrangements whilst Z was in hospital. In reaching a view on the level of distress caused we have taken account of the fact Ms X and Mr Y missed out on spending time with Z which they cannot get back. We consider this would allow the family to spend quality time together, for example on a holiday. However, the family can choose to spend it how they wish. This payment is in addition to the monies already paid by the Council.

The Council should take this action within three months of our final decision.

The Council should also take the following action to ensure other people using it's services are not similarly affected:

- Review its existing policies to set out supervision arrangements which can be made available for parents or other relatives visiting looked after children in hospital.
- Contact the second hospital and relevant council to develop a closer working relationship for when looked after children receive treatment outside the Council's area.
- Review training needs of Council officers at all levels with regards to the statutory complaints process and relevant timescales.
- Review the Council's handling of statutory children's complaints since September 2016 to ensure complaints are being dealt with in line with statutory timescales.

The Council has accepted our recommendations.

The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full

Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

The complaint

1. Ms X and Mr Y complain the Council has delayed dealing with their complaint under the statutory children's complaints procedure. Ms X and Mr Y are complaining about what happened when their youngest son, Z, was admitted to hospital. Ms X and Mr Y's son passed away whilst he was in hospital and whilst the family were subject to ongoing court action by the Council regarding their children. Ms X and Mr Y say the Council:

- failed to communicate with hospitals regarding Z's medical conditions which led to evidence being ignored and the family's explanation of his injuries being dismissed without proper investigation;
- failed to visit Z whilst he was in hospital and subject to the interim care order;
- failed to review the supervision plan as recommended by the Court;
- withheld important information from Z's medical files during the Court case;
- were responsible for the family's loss of income by failing to withdraw proceedings until the second day of the final hearing; and
- caused the family unnecessary distress by forwarding Z's post mortem results to them in an insensitive way.

Legal and administrative background

The Ombudsman's role and powers

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

3. We cannot investigate late complaints unless we decide there are good reasons. Late complaints are when someone takes more than 12 months to complain to us about something a council has done. We have investigated what happened since the beginning of 2016. ***(Local Government Act 1974, sections 26B and 34D, as amended)***

4. We cannot investigate a complaint about the start of court action or what happened in court. ***(Local Government Act 1974, Schedule 5/5A, paragraph 1/3, as amended)***

Children's social care complaints

5. The law sets out a three stage procedure for councils to follow when looking at complaints about children's social care services. At stage 2 of this procedure, a council appoints an Independent Investigator and an Independent Person (who is responsible for overseeing the investigation). If a complainant is not happy with the outcome of the stage 2 investigation, they can ask for a stage 3 review. If a council has investigated something under this procedure, we would not normally re-investigate it unless we consider the investigation was flawed. However, we may look at whether a council properly considered the findings and recommendations of the independent investigation.

6. The law says a stage 2 investigation should take no more than 25 working days and 65 working days in complex cases.

Children Act 1989

7. Section 47 of the 1989 Children Act says the Council must make enquiries when it has *"reasonable cause to suspect that a child... is suffering, or is likely to suffer significant harm"*. The Council has to decide what action, if any, it should take to safeguard the child's welfare.

8. Section 31 of the Act says the Council can apply to court for a care order if:

   - the child concerned is suffering, or is likely to suffer, significant harm; and
   - the harm, or likelihood of harm, is attributable to the care given by the parents or the child being beyond parental control.

9. Where an application is made for a care order the Council must prepare a plan for the future care of the child (care plan).

10. Where care proceedings are adjourned or the Court orders the Council to make further investigations of a child's circumstances the Court can make an interim care order. The interim order will set out who is responsible for supervision arrangements with regards to the child and what investigations should be carried out. This may involve medical reports being produced and other agencies submitting information to the Court.

How we considered this complaint

11. We produced this report after examining relevant documents and interviewing the complainant.

12. We gave the complainant and the Council a confidential draft of this report and invited their comments. The comments received were taken into account before the report was finalised.

What we found

What happened

13. Ms X and Mr Y have three children. Z was the youngest and had a number of health conditions. In 2016 Mr Y took Z to hospital with breathing problems. Z was examined by a doctor. The doctor noticed evidence of damage to Z's ribs on an x-ray and contacted the Council as it was unclear how the injuries occurred. The doctor said injuries were not linked to the medical issues Z had presented with in hospital. Ms X and Mr Y had no previous involvement with the Council's children's services department.

14. The Council contacted the family on the same day and asked about the cause of the injuries. Ms X and Mr Y both said Z had been admitted to hospital previously and was subject to a number of invasive and physical medical interventions which may have caused the injuries.

15. The Council decided to begin a safeguarding investigation to look at the cause of the injuries. In the meantime, the Council asked Ms X and Mr Y to make arrangements to be supervised around their children. The two older children would be looked after by their grandparents and other family members would supervise Ms X and Mr Y when they were with Z in hospital.

16. On the following day the Council held a strategy meeting with medical professionals and the police. A doctor from the hospital suggested the injury to Z may not have been caused whilst he was previously in hospital. This was based on a telephone call he had with the other hospital. Ms X and Mr Y maintained they were not responsible for Z's injuries.

17. A few days later Ms X told the Council the family were struggling with the supervision arrangements agreed with the Council due to being with Z in hospital and ensuring the other children were cared for. The Council said it would discuss this with Ms X once it had held a strategy meeting about what steps to take next.

18. At the strategy meeting it was decided the Council would issue care proceedings. The Council decided to assess the children's grandparents to see if they were able to supervise contact with the children. The Council then drew up a safety plan which said:

    - the two children not in hospital should remain in the care of their grandparents at the family home. When Z was discharged from hospital he would also be placed in their care;
    - Ms X and Mr Y would be supervised by named relatives during contact with the children including Z; and
    - Ms X and Mr Y were not to have overnight contact with the children at home.

19. The Council applied for interim care orders for all three children 11 days after Z was admitted to hospital.

20. Before the court hearing could take place, Z was transferred to another hospital as his condition had deteriorated.

21. The other hospital contacted the Council to ask about supervision arrangements. The Council told the hospital if staff left the room Z was in, then the parents should be asked to leave also. The hospital said it was not able to supervise contact between Z and his parents. The hospital agreed to allow the parents in the same room as Z whilst a nurse was present for one night until further discussions could take place.

22. On the same day, the Court heard the Council's application for care orders for the three children. The Court granted an interim care order whilst investigations were carried out into the cause of Z's injuries. The Court ordered that the Council's safety plan should be adopted but the Council should *"keep the interim arrangements under review"*.

23. The day after the court order was made the Council spoke to Mr Y. It told him the hospital was not able to supervise contact and he should bring a grandparent to supervise contact. Mr Y told the Council this was difficult as the grandparents were caring for the other two children and could not bring them onto the ward. Mr Y asked the Council if it could make an exception as Z was always with a nurse. The Council told Mr Y that *"the hospital are saying that this is not their responsibility but if he discussed with hospital staff and they changed their views then we could take this into account"*.

24. Two days after the interim care order was granted the Council spoke to the hospital about supervision arrangements for Z. The Council told the hospital that *"supervised contact will need to continue…* [and] *if it is possible for this to be organised by the ward at all then this is on the basis that if the nurse has to leave the room then visiting parents/family must leave too so that the family are not left*

alone with child at any time". The hospital advised that it would not be possible for it to supervise contact in this way.

25. The Court held a further hearing 11 days after the first hearing to set further directions in terms of supervision arrangements and investigations to be carried out. The Council's note of the hearing says:

"[The judge] *was of the view that any actual harm was likely to have been by a stressed parent at worst, not be maliciousness. He asked us to consider the welfare of the children vs the risk of actual harm. And if the plan is sustainable, realistic and right. He pointed out that* [the Council] *do not have a* [psychiatric assessment] *request and therefore we are not considering the parents to have any underlying* [mental health] *problems. The parents have been compliant. We are already carrying a big risk, for example if all the children wake in the night how are they going to manage supervision"*.

26. The Council agreed to change the safety plan to say the parents could stay in the family home overnight but:

- if a child wakes in the night a grandparent would attend first;
- a video monitor would be placed in the grandparents bedroom; and
- a stair gate would be fitted to stop the children coming downstairs.

27. The Council said it would review the plan before Z returned home *"as his support needs are likely to be higher and the supervision will carry more risk"*.

28. Mr Y contacted the Council by e-mail five days later to say Z's condition had deteriorated. Mr Y asked the Council to relax supervision rules whilst Z was in hospital *"so we can spend more time with our critically ill son"*. Mr Y said he and Ms X would *"like to point out the consequences of us not being able to be there at a crucial time due to the restrictions imposed by yourself. To us the risk of something happening and us not being there significantly outweighs the risks in the safeguarding policy"*.

29. The Council replied to Mr Y's e-mail on the same day and said it had called the hospital to ask if it could change the safety plan to state *"that we do not require supervision whilst a nurse is present"*. The Council said it agreed *"that the risk is low while* [Z is on the ward] *and I would like you to spend as much time as possible with* [Z]*"*.

30. The Council spoke to the hospital about supervision arrangements. The hospital said it was unable to facilitate supervision of the parents.

31. A Council social worker e-mailed the Council's legal department on the same day to ask advice about supervision arrangements for Z in the hospital. The e-mail said:

"[the hospital] *are still saying they can not supervise the contact even though I re-framed what we were asking and explained that the* [Council] *are happy with the parents being in the room while a nurse is present, and that they would leave if a nurse is not there. I explained we have assessed them as compliant and that it was suggested in court that the risk was low regarding any injuries that could be caused…* [the hospital] *have discussed it with there* [sic] *risk management and have said there is case law that states nursing staff* [cannot] *supervise contact due to a case when a child was harmed by parents while a nurse was present. They are saying they will not do this unless directed by the courts. Can you advice* [sic] *how we are to proceed?"*.

32. There is no record of a reply from the Council's legal department to this e-mail.

33. A week later Ms X contacted the Council to say Z's condition had improved. Ms X said it looked like Z has *"thin bones"* and the hospital were looking at this further.

34. Two days after this Ms X and Mr Y's solicitors wrote to the Council asking it to relax supervision requirements for Z whilst he was his hospital. The letter said:

    "… the restrictions on supervision whilst [Z] *is in hospital are particularly onerous with the parents having to be accompanied by a supervisor at all times… I question what the* [Council] *perceive as a risk to* [Z] *whilst he is in hospital with the parents visiting. Would the* [Council] *be able to reconsider their position on the need for supervision and reflect on the risk while* [Z] *is in hospital of any harm falling to him by either of the parents?"*

35. There is no record of the Council responding to this request. The Council says this is probably because there was a significant change in the circumstances of the case in the following days which meant there would be little point in replying by the time it had considered the letter.

36. Two days later a nurse from the hospital contacted the Council and said an endocrinologist was looking into possible bone disorders and a vitamin D deficiency in Z. The nurse also said Z had a chest infection and had been moved to a high dependency unit.

37. Four days after this Mr Y contacted the Council's out of hours team to say he and Ms X were not able to arrange for anyone to supervise them at the hospital with Z. Mr Y said hospital staff would not let Ms X on the ward. He asked the Council to revisit the supervision arrangements. The Council contacted the hospital and found Z was doing well. The hospital said it could not supervise contact but Ms X had been allowed limited contact by ward staff. The Council advised the hospital that no contact should take place without supervision. The Council spoke to Mr Y and advised him that he and Ms X needed to be supervised by family or a social worker and that no social worker was available that day. Ms X and Mr Y thought a social worker would be made available due to discussions that had taken place at a review meeting with the Council.

38. Two days later the hospital contacted the Council's out of hours team to say Z's health had deteriorated and staff were concerned he needed to see his mother. The Council's out of hours team agreed Z needed to see his mother and so she should be allowed to do so.

39. On the same day the hospital called the Council to say that Z was only likely to live for another hour. The hospital asked for consent to withdraw treatment. The Council advised that Ms X and Mr Y had the ability to exercise their parental responsibility with regards to medical interventions and advice and the Council would not interfere so long as the parents went along with medical advice given.

40. Later that day Z passed away. A post mortem was carried out at Ms X and Mr Y's request. Z was in hospital for almost 9 weeks in total.

41. A week later the Council told the Court it was reviewing the supervision arrangements for Ms X and Mr Y's other children.

42. A hearing took place in court a month later and the supervision requirements for Ms X and Mr Y's other children were relaxed. Ms X and Mr Y were able to care for their children during the day and night and grandparents were no longer required to live in the family home. The Court said there should still be unannounced visits

by professionals pending the outcome of the final hearing which took place 11 weeks later.

43. At the final hearing, the Council were criticised by the judge who said its case was not detailed enough. The judge asked the Council to prepare a statement setting out its current position but was not happy with the short statement provided.

44. On the second day of the hearing the Council applied to withdraw its application for a care order. The Council made a note of the Court's findings:

"No sensible person could criticise this [Council] *for commencing these proceedings in the face of the situation which presented itself following* [Z's] *admission to hospital… However, the commencement of the proceedings is simply the first step. Evidence has to be gathered, and following the gathering of the evidence the* [Council] *has to take a view. Within proceedings like this, the burden of proof rests firmly on the* [Council] *to establish its case on the balance of probabilities… There can be no doubt* [Z's] *ribs were fractured, but for the sake of clarity, the position which has been reached is that the* [Council] *have decided that those fractures cannot be attributed to parental care"*.

45. The Order withdrawing proceedings said Z's injuries remained unexplained but could not be attributed to Ms X or Mr Y's care. The Court said there were no continuing child protection issues as a result of the Court's investigation into Z's injuries. The Court asked the Home Office Disclosure and Barring Service to remove any reference or markers from Ms X and Mr Y's records relating to child protection concerns.

46. In September 2016 Ms X and Mr Y complained to the Council about what had happened. The Council decided to respond to the complaint at stage 2 of the complaints process and appointed an Independent Investigator and Independent Person on 23 September 2016.

47. Ms X and Mr Y confirmed the details of their complaint with the Council on 3 October 2016.

48. The Independent Investigator requested copies of case notes from the Council on 28 October 2016 and began interviewing officers on 22 November 2016. There was a delay because the Council solicitor involved in the case was not available until that date.

49. The Independent Investigator tried to arrange an interview with a senior officer on 1 December 2016. The senior officer said there would be a delay in arranging this as the Council was subject to an Ofsted inspection. The Ofsted inspection ended on 8 December 2016.

50. The senior officer met with the Independent Investigator and Independent Person on 20 January 2017. Following the meeting the Independent Investigator tried to contact a school about one of the children. However, no response was received despite the Council and the Independent Investigator making attempts to arrange this.

51. The Independent Investigator issued a draft report on 23 March 2017. There was a short delay as the Independent Investigator was not well and unable to complete the report.

52. The report found that:

- the Council did review the supervision plan in line with the Court's recommendations. The Council contacted the hospital to see if medical staff could supervise Ms X and Mr Y with Z but were told this was not possible;
- the Council failed to provide a social worker to supervise Ms X's visit to see Z in hospital. The Council said it could provide someone to supervise visits but failed to record this on Z's file;
- the Council failed to tell Ms X and Mr Y that it had taken one of their other children to be examined in hospital;
- when the Council took Ms X and Mr Y's other child to hospital it failed to ensure the child was accompanied by someone familiar;
- there was no fault in the Council providing Ms X and Mr Y with details of the Samaritans when Z passed away but it should have provided them with details of other organisations which could have offered support;
- the Council gave Ms X and Mr Y unclear advice about whether medical staff could supervise their visits to hospital when relatives were not available;
- the Council failed to give Ms X and Mr Y or their relatives any advice regarding possible benefit entitlement and other financial support available;
- the Council sent Z's post mortem report to a number of parties involved in the court proceedings including Ms X and Mr Y's solicitors. The solicitors were responsible for sharing this information with Ms X and Mr Y not the Council;
- the Council failed to visit Z whilst he was in hospital however the Council was *"trying to be respectful of the family's feelings"*;
- the Council failed to advise Ms X and Mr Y the reasons why it had decided to seek care orders rather than supervision orders a few days before care proceedings started; and
- the Council had been advised that Z's bones were fragile following further tests and examinations in hospital. The Independent Investigator said any change in medical opinion about Z's injuries was a matter for court.

53. On 10 April 2017, a senior Council officer advised the Council's complaints department that it was *"likely that we will seek Counsel's advice"*. The officer said this was because there were *"some potentially very fundamental practice implications associated with some of the conclusions which could have a far reaching and damaging impact on the services ability to discharge its statutory duties where there are unexplained injuries to a child"*. The officer said the matter needed *"very careful consideration"*.

54. The senior officer provided the Independent Investigator with further comments on 9 May 2017.

55. The Independent Investigator responded to the Council on 16 June 2017. The Investigator said they would add further explanation regarding advice given to grandparents regarding attendance at court. The Investigator also clarified that they were not recommending a "serious case review" but the Council should review what had happened to see if any lessons could be learned. The Investigator said Ms X and Mr Y wanted to be *"fully involved"*.

56. Ms X and Mr Y complained to us on 25 July 2017. They said the Council was taking too long to consider their complaint. Our investigator contacted the Council

for an update on 16 August 2017 and was advised that the Council was making some amendments to the stage 2 report and it would be sent to Ms X and Mr Y later that week.

57. We asked the Council for a copy of the stage 2 report on 9 October 2017 as it had still not been issued to Ms X and Mr Y. The Council did not respond and so we asked for this again on 9 November 2017.

58. On 10 November 2017, the Council provided us with a copy of the original stage 2 report from March 2017. We forwarded this to Ms X and Mr Y.

59. On 20 December 2017, we contacted the Council as Ms X and Mr Y had still not received an adjudication letter about their complaint. We suggested the Council consider whether a financial remedy was appropriate given the delays which had occurred already.

60. The Council met with Ms X and Mr Y to discuss their complaint in January 2018.

61. The Council issued its adjudication letter on 8 February 2018. The Council agreed with the findings of the stage 2 investigation. The Council said it also agreed with Ms X and Mr Y that they had offered an explanation of Z's injuries but that this was not included in the stage 2 investigation.

62. The Council said it would:

- remind officers to record the outcome of reviews and any action to be taken as soon as possible;
- pay Ms X and Mr Y £500 to recognise the delays in responding to their complaint;
- remind officers of the importance of attempting to make alternative arrangements for supervision as quickly as possible;
- remind officers of the importance of ensuring they have accurate contact details for families;
- ensure information is available on a range of different support services and agencies available to families;
- assess how much money may have been available to recompense family members for travelling to and from the hospital to supervise contact and pay the recommended amount. The Council agreed to pay the family £1232.21 to cover these costs; and
- remind officers of the importance of visiting families even if families may not want this involvement.

63. The Council said it would not recompense the family for four months of lost wages which Ms X and Mr Y had asked for. The Council also said it could not change Z's records so he was no longer a child who died in care. The Council said it realised this was *"upsetting"* for Ms X and Mr Y but it was not able to change the records.

Conclusions

Complaint handling

64. The law says the Council has 25 days to investigate a complaint at stage 2 of the statutory complaints process. Where the Council is not able to meet the timescale, it must write to the complainants letting them know this is the case and issue its final response within 65 days of receiving the complaint.

65. In Ms X and Mr Y's case the date the Council received the complaint was 3 October 2016 according to the relevant legislation. This is because they confirmed the final details of their complaint in writing on this date.

66. The Council did not issue its final response to the complaint until 8 February 2018. Overall it took the Council 343 working days to respond to Ms X and Mr Y's complaint. This is 278 working days more than is allowed in the statutory regulations. This is fault.

67. There are long periods of time where little or no action was taken regarding the complaint. Although the Council was subject to an Ofsted inspection when Ms X and Mr Y first made their complaint this was concluded on 8 December 2016 and there is no evidence of urgency from the Council to bring the matter to a close after this date.

68. This was a sensitive complaint about issues which had caused Ms X and Mr Y a great deal of distress. There is no evidence in the complaints file that the Council recognised this or that any attempts were made to prioritise the complaint even once we became involved.

69. When the Council responded to Ms X and Mr Y's complaint it apologised for the delay in providing a response to the complaint. It said this was *"partly due to managers wanting to consider the lessons they needed to learn so they could respond clearly about this"*. There is no evidence of any such discussions on the Council's records. The Council asked for clarification on whether the Independent Investigator was recommending a "serious case review" take place but that is as far as discussions went.

70. The Council has failed to offer a genuine apology for the delay investigating Ms X and Mr Y's complaint. However, it has paid Ms X and Mr Y £500 for the unnecessary time and trouble they were put to because of the delay. This payment is in line with the our guidance on remedies. The Council maintains its apology was genuine.

71. Due to the length of time it has taken the Council to complete its stage 2 investigation we decided to investigate Ms X and Mr Y's complaints without the need for a stage 3 investigation. We asked Ms X and Mr Y if they would like the Council to consider their complaint at stage 3 but they declined due to the time that had already passed.

72. We would not normally re-investigate a complaint unless we consider the investigation was flawed. However, in the absence of consideration at stage 3 of the statutory process we have investigated parts of the complaints where Ms X and Mr Y were not happy with the Council's response.

73. We have also decided to investigate what happened since January 2016. This is because of the significant delays in the Council responding to Ms X and Mr Y's complaint.

The Council failed to communicate with hospitals regarding Z's medical conditions which led to evidence being ignored and the family's explanation of his injuries being dismissed without proper investigation.

74. The courts have considered the Council's evidence and reasons for starting court action with regards to Ms X and Mr Y's children. When proceedings were withdrawn the Court acknowledged Ms X and Mr Y were not at fault for injuries to Z but also that it was not critical of the Council for taking action in the first place.

75. As these issues have already been before the courts we must stop our investigation into this part of the complaint.

The Council failed to visit Z whilst he was in hospital and failed to review the supervision plan as recommended by the Court.

76. The Court ordered the Council to keep the contact arrangements under review. Therefore, the Council was responsible for contact arrangements so this is something we can investigate.

77. The Council upheld Ms X and Mr Y's complaints about its failure to visit Z in hospital. It said a social worker should have visited Z every 6 weeks. However, it failed to consider the impact this had on Ms X, Mr Y and Z. That impact is linked to Ms X and Mr Y's complaint about the Council's failure to review the supervision plan, which was not upheld, so we are considering these two points together.

78. The social worker responsible for the case was interviewed by the Independent Investigator on 20 October 2016. She said:

"I did not visit [Z] *in hospital. This was partly because I wasn't sure it was appropriate given how ill he was. However, looking back, it would have helped me see what they were experiencing. I would have given them my support but they evidently did not want me in their lives.* [They] *did not want to have* [children's services] *involvement… Going to the hospital to see a very tiny, ill baby was not going to inform my plan but I needed to prioritise* [the other children]*"*.

79. Relationships between social workers and parents can, and perhaps will inevitably be strained. There is no evidence Ms X or Mr Y rejected support from social workers. Even if they had we would have expected the social worker to continue to try and build a working relationship with them in the interests of the children. Records of contact show Ms X and Mr Y requesting more support especially in managing the supervision arrangements imposed by the Council. Visiting Ms X, Mr Y and Z in hospital would have allowed the Council to gain a better understanding of the difficulties they faced being with Z. Ms X and Mr Y say they both stayed with Z 24 hours a day during a previous unrelated hospital admission.

80. Going to the hospital would also have allowed the Council to assess how Z's emotional needs were being met. The early stages of a baby's development are strongly linked to forming a strong bond with care givers. The Council's plan was for Z to live with his grandparents on discharge and the Council was aware Ms X and Mr Y were only able to spend 4 to 6 hours a day with him. There was nothing in the care plan to say how Z's emotional needs would be met either by his grandparents or Ms X and Mr Y whilst he was in hospital. This is fault.

81. As a result of the failure to consider Z's emotional needs the Council failed to properly review supervision arrangements. The Court said the Council should *"consider the welfare of the children vs the risk of actual harm"* when carrying out that review.

82. The Council's review consisted of a series of telephone calls to hospital staff. The Council did not visit the ward to see what arrangements were in place and whether supervision was necessary. Had the Council gone to the hospital to see the arrangements and spoken to hospital staff in person it seems likely supervision requirements could have been relaxed or additional supervision arranged so Ms X and Mr Y would have been able to spend more time with Z.

83. Ms X and Mr Y repeatedly asked the Council to review the supervision arrangements to allow them to spend more time with Z. However, the Council sought to blame the hospital for refusing to supervise contact. Ultimately it was the Council and not the hospital who were responsible for the supervision arrangements being in place. The Council failed to review its position considering the hospital's response and Z's emotional needs. This is fault.

84. The Independent Reviewing Officer was interviewed by the Independent Investigator as part of the stage 2 investigation. She said the Council *"talked about whether there were any third-party services that could assist with supervising contact. However, the parents preferred family members who were known to the children, so we looked at extending the pool of relatives who could assist"*.

85. There is no evidence the family were offered third party services to provide supervision of their contact with Z. The Council says it offered for a social worker to supervise contact, however this was not recorded at the time the offer was made and when Ms X and Mr Y asked for a social worker to come to the hospital there was no one available. As a result, Ms X and Mr Y were not able to see their son that day and he was in hospital without anyone familiar being with him.

The Council withheld important information from Z's medical files during the court case.

86. We cannot continue to investigate the availability of medical information during the court case. This is a matter for the courts.

The Council were responsible for the family's loss of income by failing to withdraw proceedings until the second day of the final hearing.

87. It is clear from the Council's records the courts were not happy with the Council's position on the first day of the final hearing. As a result of this the Council decided to withdraw proceedings on the following day.

88. We cannot investigate complaints about what happened in court and so we cannot investigate this part of the complaint further.

The Council caused the family unnecessary distress by forwarding Z's post mortem results to them in an insensitive way.

89. The post mortem results were sent to Ms X and Mr Y by their own solicitors as part of a bundle of documents. Therefore, the Council is not responsible for the way the post mortem results were shared with the parents.

Recommendations

90. To remedy the injustice caused, we recommend the Council:

- write to Ms X and Mr Y to apologise for the failure to review supervision arrangements for Z and the fact this meant they lost out on spending time with their son. The Council should also apologise for the delays in dealing with Ms X and Mr Y's complaint and for misleading them in relation to the reasons for those delays; and
- pay Ms X and Mr Y £2000 for the distress caused as a result of the failure to properly review supervision arrangements whilst Z was in hospital. In reaching a view on the level of distress caused we have taken account of the fact Ms X and Mr Y missed out on spending time with Z which they cannot get back. We consider this would allow the family to spend quality time together, for example

on a holiday. However, the family can choose to spend it how they wish. This payment is in addition to the monies already paid by the Council.

91. The Council should take this action within three months of our final decision.

92. The Council should also take the following action to ensure other people using it's services are not similarly affected:

- Review its existing policies to set out supervision arrangements which can be made available for parents or other relatives visiting looked after children in hospital.
- Contact the second hospital and relevant council to develop a closer working relationship for when looked after children receive treatment outside the Council's area.
- Review training needs of Council officers at all levels with regards to the statutory complaints process and relevant timescales.
- Review the Council's handling of statutory children's complaints since September 2016 to ensure complaints are being dealt with in line with statutory timescales.

93. The Council has accepted our recommendations.

94. The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

Decision

95. We have completed our investigation. This is because we have found fault causing injustice and the action we have recommended is a suitable way to remedy this.