Agenda Item	8
Report No	AC/11/24

THE HIGHLAND COUNCIL

Committee: **Audit Committee**

Date: **21 March 2024**

Report Title: **Scottish Public Services Ombudsman Cases Upheld**

Report By: **Interim Executive Chief Officer, Performance and Governance**

1. Purpose/Executive Summary

1.1 This report provides information on the cases that have been upheld by the Office of the Scottish Public Sector Ombudsman (SPSO) since this was last reported to the Audit and Scrutiny Committee on 23rd March 2023.

1.2 Since that report, one case has been determined by the Ombudsman and was upheld. This report provides details of the SPSO's decision.

2. Recommendations

2.1 The Committee is asked to:

i. Consider the outcome of the upheld case; and

ii. Note that the SPSO's recommendations have now been carried out.

3. Implications

3.1 Resource and Risk: A focus on improving performance in handling customer complaints reduces the Council's risk of public exposure to criticism and reduces the cost to the Council of managing failure demand.

3.2 Legal & Community (Equality, Poverty and Rural), Climate Change / Carbon Clever, Gaelic: There are no implications arising from this report.

3.3 Health and Safety (risks arising from changes to plant, equipment, process, or people) There are no health and safety risks arising from this report.

4. Background

4.1 The Scottish Public Services Ombudsman (SPSO) was set up in 2002 to investigate complaints about organisations providing public services in Scotland, including local authorities. The SPSO investigates complaints where a member of the public claims to have suffered injustice or hardship as a result of maladministration or service failure and only investigates cases when the complainant has already exhausted the formal complaints procedure of the organisation concerned.

4.2 Since 23rd March 2023, the SPSO has only fully investigated 1 complaint against the Council. This low figure reflects well on the Council's handling of complaints and on the quality of information provided to the SPSO during initial investigations.

4.3 Details of the upheld complaint are provided below. A summary of the SPSO's decision is published on their website and the full text is included in Appendix 1

5. Upheld / Partially Upheld Complaints

5.1 Case 202107467, Child services and family support

The complaint related to the Council's handling of allegations that the complainant's child made against them. The SPSO did not uphold this complaint but did uphold a subsequent complaint about the Council's handling of disclosures made by their child to social workers regarding a previous overdose.

5.2 A key reason for the SPSO's decision to uphold this part of the complaint was the Council's inability to provide records of the conversation with the child with clear reasoning as to why the parents were not informed.

5.3 The following recommendations have been made:

1. Apologise to C and their partner for the issues highlighted. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

   What we said should change to put things right in future:

2. That the Council share this decision with the social work team with a view to reminding them of the importance of recording all discussions and decision making considerations in child protection case notes.

5.4 These recommendations have now been implemented and the SPSO has been advised.

Designation: Interim Executive Chief Officer, Performance and Governance

Date: 04/03/2024

Authors: Miles Watters, Corporate Performance & Information Governance Manager

Background Papers:

Appendix 1

SPSO case 202107467 – Decision summary

C complained about the council's handling of allegations that their child made against them, including decisions taken to remove their child from the family home on the evening of the incident, but then considered safe to return the following day. C also complained about a lack of support for their family following the incident. C made a subsequent complaint about the council's handling of disclosures made by their child to social workers regarding a previous overdose.

In response to the complaints, the council said that once a child protection issue was raised by C's child, this was responded to quickly and in line with child protection procedures. Decisions about where C's child should stay whilst police investigations were ongoing were taken in collaboration with the family and it was determined following a risk assessment that there was no grounds to require C's child to stay away from the family home. The council explained the nature and purpose of follow up meetings.

With respect to disclosures made by C's child that they had previously taken an overdose, the council said that the social worker's professional opinion was that it was not necessary to pass this information on to the child's parents, and instead recorded a note of the incident. The council did however acknowledge that there was no record of why the social worker had come to this determination and course of action.

We took independent advice from a social work adviser. We found that whenever information is provided concerning actual or alleged abuse, this must be investigated and we considered that actions taken by the council's social worker to be reasonable in this regard. With respect to decision making around removing C's child from the family home, whilst the circumstances are disputed, the records indicated that there were discussions with the family about the decision making in this regard and additional factors, including the lateness of the day, were taken into consideration. The approach in the circumstances was therefore considered to be reasonable.

With respect to C's child returning to the family home the following day, we found that there was no immediate risk to C's child should they stay at home and it was reasonable for them to return home the day following the incident. On this basis, we did not uphold C's complaint about the appropriateness of the council's Child Protection investigation.

In considering C's concerns about the handling of their child's disclosure of a previous overdose, we acknowledged the council's position that it may be appropriate in some circumstances not to share such information with a child's parents, such as in circumstances where the child does not want the information shared. However, we found that there was no evidence of such a discussion having taken place, or of the reasoning behind decisions taken not to share this information with C or their partner. We therefore found that there was a failure by the social worker to record a discussion with C's child and the reasons for not informing their parents of the overdose. On this basis, we upheld the complaint.

Recommendations
What we asked the organisation to do in this case:

Apologise to C and their partner for the issues highlighted. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

That the council share this decision with the social work team with a view to reminding them of the importance of recording all discussions and decision making considerations in child protection case notes.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.