social work services INSPECTORATE

Report of the Inspection of

Scottish Borders Council Social Work Services for People Affected by Learning Disabilities

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TABLE OF CONTENTS

PREFACE 3

INTRODUCTION 5

SECTION I: ANALYSIS 7

SECTION II: RECOMMENDATIONS 23

APPENDIX I: REMIT OF INSPECTION 33

PREFACE

In March 2002, a woman with learning disabilities was admitted to Borders General Hospital having suffered extreme levels of physical and sexual abuse within her household over an extended period. In September 2002, three men were imprisoned for this abuse.

This woman had been in receipt of social work services from Scottish Borders Council and its predecessor authorities and from NHS Borders since her early childhood. The abuse she suffered had occurred throughout the period of the agencies' involvement, escalating to extreme levels during the four month period leading up to her hospitalisation.

Although only one individual has been at the centre of the media attention surrounding this case, other individuals within the same social network, receiving similar services from the Council and Health Board, also suffered severe forms of neglect and abuse over a period of some 3 decades.

Detailed examination of this case by both the Social Work Services Inspectorate and the Mental Welfare Commission for Scotland has highlighted significant failings on the part of agencies whose primary responsibility is the protection and promotion of the health and well-being of vulnerable people.

The failure of agencies to respond effectively to repeated occurrences of abuse of people with learning disabilities appeared from the records to reflect at best a misunderstanding of the complex and fragile balance between individuals' rights to self-determination and their rights to protection. A balance which we all have a duty to understand and to manage successfully if we aspire to a truly inclusive society.

The implementation of *The same as you? A review of services for people with learning disabilities* has seen excellent developments across Scotland in services that promote independence, self-determination and choice. The underpinning principle of *The same as you?* is that of social inclusion – involvement of all, regardless of disability, in all aspects of community life; respect for people's aspirations; and provision of the support needed to achieve those aspirations. People with learning disabilities who are abused, neglected and exploited because they are living unsupported in the community suffer the worst form of social exclusion. We depend for their meaningful inclusion on a better understanding of how support and protection contribute to self-determination, choice and involvement.

The detailed recommendations in this report – including proposals for improved staff training, clearer management accountability and quality assurance, more effective joint working and legislative change – should contribute to the necessary changes in attitude, service delivery and quality of life for people with learning disabilities that the events in this case have so painfully shown to be necessary.

INTRODUCTION

1. In response to the events of March 2002, Scottish Borders Council commissioned from David Stallard an independent report into the actions of its Department of Lifelong Care – responsible for the delivery of social work services. David Stallard's report was scrutinised by Andrew Reid, a second external consultant, to confirm its independence. A third report was subsequently commissioned by the Council from social work consultant Anne Black to consider the need for disciplinary action in respect of staff. The remit of the reports commissioned by the Council was largely limited to the four month period leading up to the individual's hospitalisation.

2. The three reports set out a number of very concerning actions (or inaction) in respect of this case by a range of staff at varying levels of seniority within the Department of Lifelong Care.

3. In June 2003, following examination of these three reports by the Chief Inspector of Social Work, the Minister for Education and Young People asked the Social Work Services Inspectorate (SWSI) to carry out an inspection into the social work services provided to people with learning disabilities by Scottish Borders Council's Department of Lifelong Care. It was considered essential for a thorough examination of the relevant facts that no time limit be imposed on the investigation, and as a result the remit of SWSI extended to the point of the individual's and relevant others' earliest contact with social work services in the 1970s. The remit for the inspection is set out at Appendix I.

4. Neither the Council-commissioned reports nor the SWSI investigation could include a detailed examination of the health services provided in this case. However, within a similar timescale, the Mental Welfare Commission (MWC) carried out an investigation into the involvement of health services, paying particular attention to joint working between health and social work. The service users involved had contact with many different parts of the health service, and the MWC's inquiry has identified a number of areas where improvements can be made in the way the needs of vulnerable people with learning disabilities are recognised and responded to.

5. Despite the different scope and remit of the SWSI inspection and the MWC inquiry, the two organisations liaised closely throughout their respective investigations to ensure appropriate information-sharing and avoidance of duplication wherever possible.

6. In order to protect the identities of the individuals involved, the MWC does not usually publish full reports of its investigations. Reports are provided to the key agencies, in this case NHS Borders and Scottish Borders Council and – in anonymised form – to Scottish Ministers.

7. The SWSI inspection began by establishing the facts of the case. Scottish Borders Council has accepted SWSI's findings of fact as an accurate record. Due to the complexity of the relationships of the service users involved in this case, it is not possible to anonymise the findings of fact, and it would not be in their interests for these findings to be published.

8. SWSI's full findings of fact, analysis and recommendations have been provided to the Chief Executives of Scottish Borders Council and NHS Borders, the Chief Constable of Lothian and Borders Constabulary, the Mental Welfare Commission, NHS Quality Improvement Scotland, Her Majesty's Chief Inspector of Constabulary and relevant Scottish Ministers.

9. Notwithstanding the absolute right of the individual service users in this case to protection from the further distress that identification would inevitably bring, it is essential that the important lessons from this case are fully understood and learned by all the agencies tasked with the responsibility for protecting vulnerable people.

10. In order both to safeguard individuals' rights and to ensure that the public interest is served, this report sets out in full (but anonymised form) SWSI's analysis of the facts, and the recommendations that flow from it.

11. Prior to the announcement of the SWSI inspection in June 2003, some Scottish Borders Council staff had been interviewed on a number of occasions by up to three separate report writers. Some of these staff were also to be interviewed in the course of the MWC inquiry. In recognition of the stress on staff of repeated scrutiny of their actions in a high profile case attracting critical media attention, and because of the time elapsed between the critical incidents in this case and the inspection, staff were not asked by SWSI to submit to further interviews. The transcripts of all previous interviews were made available to SWSI.

12. Scottish Borders Council staff have not been identified in this report; however, they are named in the findings of fact and are therefore known to Scottish Borders Council. Responsibility for staff management, development and discipline rests with Scottish Borders Council as employer.

13. The key service users in this case were interviewed by SWSI inspectors. Their input to the investigation was critical and their contribution is very much appreciated. The full co-operation of Scottish Borders Council staff is also appreciated.

SECTION I: ANALYSIS

14. The case files describe a number of individuals whom the social work services of Scottish Borders Council and its predecessor authorities attempted, often ineffectually, to help over 30 years. These individuals, between them, had numerous complex difficulties, including serious physical disabilities, learning disabilities, challenging behaviour, physical and sexual aggression, depression and physical and emotional neglect.

15. This analysis recognises the inherent difficulty of examining under a modern spotlight the actions of a service going back 30 years. The primary focus is on recent years, but these can really only be understood by taking a longer perspective. Early events cannot be ignored, nor can the knowledge that a number of staff had of the case from their long-term involvement. It is clear from the department's case records that relevant information on which staff could have been expected to act had been available for many years, and should have been considered and assessed from a modern perspective.

16. The purpose of this report is to identify failings only in as much as identification will highlight the changes in culture and practice that are essential to the future improvement of services – services that must be delivered in accordance with expected standards for modern social work provision and with the Scottish Social Services Council Codes of Practice, as approved by Scottish Ministers. Ownership by staff of both individual and system responsibility for the failure to protect very vulnerable individuals is a critical element in the recovery of public confidence in the social work service.

17. The extreme vulnerability of a number of individuals, and the high risk of serious sexual and physical abuse of them, was evident from information noted in social work files going back to the 1970s. The repeated failures of social work to act effectively in response to allegations of abuse over some 3 decades undoubtedly contributed to the serious sexual abuse of at least 3 individuals and to the serious physical neglect of another.

18. The abuse took varied forms, including emotional, physical, sexual and financial exploitation. It is clear from the records that several people contributed to the neglect and abuse suffered by these vulnerable individuals, whose expectations of protection lay with the statutory agencies carrying out their obligations effectively. In the event, it was left to a neighbour to recognise the seriousness of the situation in March 2002 and to contact the police, following which decisive action was taken.

19. The main conclusions of this report are grouped below in response to a series of questions. The questions cover: the standard of current care arrangements; whether Scottish Borders Council social work service could and should have acted differently; the Council's managerial and personnel practices; whether the Council's action plans have the capacity to prevent similar failings in the future; and whether there are learning points for wider application across Scottish authorities.

Question 1: Are the present care and support arrangements for the key individuals in the case of a satisfactory standard?

20. Four individuals are living in registered care homes. All have said that they are happy and feel well cared for in their current placements, acknowledging good relationships with care staff. However, all have aspirations to lead more independent lives in the future.

21. Some care plans and personal support plans have been developed, however, none of the individuals appears to have a personal life plan that sets out their hopes and aspirations and considers what alternative arrangements should be worked towards in order to promote their potential for independence to the maximum.

22. None has been provided with the service of an independent advocate, and only one is legally represented. In the light of the case history and of the identified failings of the department, advocacy and individual legal representation would ensure the interests of all the individuals involved were promoted independently.

23. The local authority has been the legal guardian of one individual since 1999. During the period of guardianship the individual accrued debts of up to £3000. Protection of adults who are vulnerable to financial exploitation due to a mental disorder or to incapacity is a duty of local authorities and is implicit in the role of guardian. Some responsibility for this situation lies therefore with the local authority.

24. A claim for criminal injuries compensation for one individual was initiated some eighteen months into the two-year time limit for submissions. No claims were considered for any of the other individuals who may be eligible. Eligibility should have been tested within appropriate timescales for all individuals concerned. This issue underlines the value of independent advocacy and personal legal representation.

25. In October 2003, the Chief Social Work Inspector raised with the Chief Executive of Scottish Borders Council concerns regarding the current service being provided to the individual service users in this case, in order that they may be addressed prior to the finalisation of this report. Scottish Borders Council responded promptly to these concerns, although some of the issues remain part of the recommendations of this report.

Question 2: Could Scottish Borders Council have been reasonably expected to take significantly different action on one or more occasions, which might reasonably be judged likely to have led to different outcomes?

26. The repeated horrific sexual and physical abuse for which 3 men were convicted in 2002, could have been prevented had the department acted on the mounting evidence available over the previous two decades. The department relied inappropriately on one individual service user to protect a number of the victims in this case. When this person was no longer available to fulfil this role, the department should have feared an escalation in the nature and extent of sexual, emotional and financial abuse that individuals were likely to suffer.

27. Unequivocal prompts to act occurred routinely over the decades prior to March 2002. Between 1976 and December 2001, 28 allegations of physical and/or sexual abuse were reported to social work. In 1998, the department collated detailed historical concerns and presented these as evidence on which to base the successful protection of a child. Between early December 2001 and 24 February 2002, there were 16 separate contacts or referrals by the individuals themselves, members of their family or social work staff, expressing concerns. Each one of these events should have initiated decisive action, but none did. It was not until March 2002 that the actions of a concerned neighbour led to protective action by police and social work.

28. One characteristic of this case is the unco-ordinated approach taken to assessment, service provision and monitoring of an increasingly complex and very high risk case. Formal assessments were rare and of a very poor standard, when recorded. The level of recorded service input fell far short of that required to address the individuals' high degree of need. There was a lack of information-sharing and of focused monitoring of decisions taken, and an inconsistent approach to risk management. This contributed to an ineffective engagement with service users to address their behaviour or alleviate their suffering.

29. Individually, departmental staff had access to a significant amount of relevant information. This information included concerns reported to social work by other agencies (police and health) and members of the public. Had this information been considered and acted on, it could have provided the basis on which to respond to the individuals' needs. The failure to share and to act on information is a characteristic repeated throughout the case history. Critical examples include knowledge:

    - of a history of sexual abuse allegations
    - of the reluctance of potential protective figures to accept the allegations
    - of the living arrangements of individuals
    - that access was being denied to social work staff at critical periods
    - that essential support services had been withdrawn

30. This lack of any authoritative co-ordination, sharing and consideration of all the information held on each of the individuals and of its interaction was a critical failure in the effective management of this case.

31. Although a number of case discussions, case conferences and review meetings considered various aspects of individuals' circumstances at different stages in their lives, there was often little consideration of who may have critical information and should therefore attend meetings, whether staff from within the department, from other agencies or service users themselves.

32. The first formal assessment of one of the key individuals as an adult was completed in October 1998. The assessment is of very poor quality. It is hand-written and contains only 147 words. It deals with a very limited aspect of the person's life. There is no evidence that:

    - it was needs-led
    - the person was interviewed as part of its completion
    - it was shared with the person
    - departmental information on other relevant people was sought
    - health colleagues were invited to contribute
    - any of the allegations of abuse against the individual or against others were considered

33. By the time of the assessment, the individual had alleged sexual abuse on ten separate occasions. One of the alleged abusers had admitted having sexual intercourse with the victim once. The department had in its possession letters, apparently written by one of the alleged abusers, indicating that the allegations may be true. The grounds of referral of a child to the Children's Hearing had been established in the Sheriff Court; these included sexual abuse of the individual by one of the alleged abusers. Key health and social work staff considered the individual's home to be an unsuitable environment for other service users, and agreed that protective action should be taken if necessary to prevent them from living there. None of this is considered as part of the individual's community care assessment.

34. In 1998, this was an unacceptable standard of practice, unrelated to the existence of policy and procedure.

35. Intervention with one of the subsequently convicted abusers indicates no systematic consideration of the risks that his behaviour posed. No analysis was made of his history of predatory behaviour and no plan was designed to address this behaviour and manage the risks that he represented over the years.

36. Case recording generally falls short of being fit for purpose and well below the standards set by departmental procedures, including no indication in any of the files that these have been seen by supervisory staff, as is required. It is very difficult to identify workers from their contact recording. Many reports are unsigned and undated. The files show no care or protection plans in response to allegations of abuse, and often no record of any significant action taken in response to the allegations. Many critical periods in the life of individuals in this case are recorded in contact summaries only – some covering three months, but on occasion covering up to 15 months.

37. Contact and transfer summaries are of poor quality and do not address salient points. The management of case transfers was equally poor.

38. The lack of comprehensive assessments and of care and protection plans resulted in unfocused contacts with service users, with no clarity of purpose for intervention, and no opportunity for effective monitoring of progress. This is both the reason for, and the outcome of, little or no effective intervention at critical times. With clear goals and expectations of intervention, the decision to apply for statutory measures – e.g. supervision or guardianship – can be based on an understanding of how these measures would help to secure protection and care.

39. The history of the case is characterised by social work staff refusing to consider statutory intervention as a means of providing the framework within which inappropriate, potentially criminal, behaviour can be challenged, and protection given. Instead of using available statutory provision to ensure compliance of individuals with care or protection plans, staff used the likelihood of non-compliance as the justification for not intervening. For example:

    - the social worker supervising a Probation Order in 1989, successfully recommended the deletion of a condition of the Order when the offender refused to comply with it

    - the social worker successfully recommended the termination of the same Probation Order because: *"…there is no productive work being undertaken… and little prospect of doing so …"*

- at a case conference to consider allegations of sexual abuse held on 12 September 1984, the social worker expressed concern that the very fact of holding the meeting could be seen by service users as a betrayal of confidences. The case conference took the view that because the nature of the *"At Risk Register"* would not be understood, there was little point in placing anyone's name on it as this may have a detrimental effect on the relationship between service users and social workers

- the social worker's report to the Children's Reporter dated 18 September 1986 minimised any potential risk, stating that the social worker was: *"sure that if anything has happened, this is unlikely to happen again."* The report recommended that formal supervision was not appropriate as: *"...it is difficult to see what outcome might be helpful"*

40. These examples are indicative of attitudes that persisted over the years and that are reflected in the department's failure to address the risk to vulnerable individuals in the critical period from December 2001 to March 2002.

41. The essence of social work with vulnerable adults is a constant balance between promoting independence and self-determination and providing appropriate levels of protection. This balance is articulated clearly in the Scottish Social Services Council Code of Practice for social service workers, which includes: *"Recognising that service users have the right to take risks and helping them to identify and manage potential and actual risks to themselves and others (section 4.1);...Following risk assessment policies and procedures (section 4.2); ...Taking necessary steps to minimise the risks...(section 4.3)"*. There are several examples of responses from one social worker that do not reflect a professional consideration of this balance. At best they indicate a lack of knowledge and a lack of understanding of the central issue; at worst complacency and unprofessional conduct:

    - on 8 January 1996, a discussion between the social worker and their senior was recorded, in which serious concerns about one individual were discussed. These concerns included possible abuse and exploitation. The outcome of the discussion was that the social worker should discuss this matter with a Mental Health Officer colleague to consider the case for guardianship. The social worker recorded instead that: *"I however felt* [the person] *wanted these problems and that there was not enough evidence that* [the person] *cannot make* [their own] *decisions"*

    - in February 2002, a senior social worker informed the social worker that an individual was staying out overnight, raising concerns for their safety. The social worker expressed the view that this was not a cause for anxiety as the person was considered to be *"streetwise"*

    - on 9 January 2002, the social worker visited the home of a number of the individuals involved in this case; the house was described as unkempt; one person was seen crawling on the floor; no-one else was seen; "*visit pointless"* was recorded in the case file, and no action was taken

    - on 31 January 2002, an individual was reported as missing to the social worker, whose advice was not to become concerned until the following day

42. Respect for individual choice and autonomy was not balanced by a formal consideration of the interplay between the social environment and the impact of the individual's learning disability. The role of health colleagues, particularly clinical psychologists, was crucial to the assessment process, but remained marginal.

43. Knowledge and understanding of the provisions of statutory intervention, together with effective multi-disciplinary care planning, could have assisted in achieving the necessary balance of protection and autonomy. Guardianship and its consideration throughout the history of this case provide an example of how a lack of such knowledge and understanding prevented the effective discharge of the department's duties.

44. Until April 2002 (implementation of Part 6 of the Adults with Incapacity (Scotland) Act 2000), guardianship under the Mental Health (Scotland) Act 1984 was an essential legislative tool for protecting the health and welfare of vulnerable people with a mental disorder. Between 1994 and 1998 only one application for guardianship was approved in Scottish Borders. This was despite the Mental Welfare Commission expressing concern throughout the 1990s that staff in some authorities appeared reluctant to use guardianship, possibly due to their lack of knowledge, experience and understanding of its provisions.

45. Examination of recording and correspondence in respect of this case suggests that consideration of the use of guardianship was not informed by direct experience, knowledge or training, or by guidance issued by the Mental Welfare Commission in its Annual Reports, but rather by flawed assumptions about guardianship's potential value.

46. Social work staff's conviction that guardianship powers were limited and could not be implemented effectively is a critical factor in the Council's failure to protect the victims in this case. One of the reasons consistently given was that it would be difficult to establish the medical and welfare grounds required for an application for guardianship. Establishing medical grounds for guardianship is not the responsibility of social work staff. This is the professional and legal responsibility of psychiatric colleagues who consistently expressed the view, recorded at various points, that a number of individuals in this case met the medical grounds for guardianship.

47. The welfare grounds were self-evident in the case files over a number of years. The behaviour of one of the subsequently convicted abusers – accepted as fact for a number of years in the files – represented a risk well beyond the established threshold for successful guardianship applications across Scotland.

48. In the light of this known risk, and given the views of medical colleagues, it is difficult to accept the justification for not putting the matter of guardianship before a Sheriff. This justification included the concern expressed by social work staff that the Sheriff may question why an application had not been made earlier.

49. Social work staff failed to articulate a clear plan for protection and support, based on a detailed assessment and analysis of risk factors. The development of such a plan would have highlighted the need for statutory intervention to ensure its implementation.

50. Having viewed the case and the usefulness of guardianship in a certain light, staff considered each new incident, allegation or expression of concern in the same light. They failed to reassess the situation, despite an overwhelming accumulation of evidence over time, the weight of which should have affected their assessment of risk. They failed to assess the

compound impact of these allegations, incidents, admissions and concerns on the health and safety of the individuals concerned. Neither did they identify the escalation of neglect and violence that occurred within the household from November 2000.

51. Staff's lack of understanding of the provisions of guardianship was evident in their management of one individual's case following a successful application for the person to be subject to guardianship in June 1999. Guardianship was only sought when access was being denied; but this blocking of access only interfered with a very passive monitoring of the case by social work. When guardianship did provide access to the individual, little appears to have changed in the management of the case. Abuse and financial exploitation in the household continued. Given the person's continued exposure to risk while subject to guardianship, it is clear that its duties and powers were unknown to staff responsible for its implementation.

52. The protection of finances of all those who were exploited during the case was never adequately considered. The authority has a clear statutory duty to ensure the protection of the finances of people with a mental disorder unable to do so themselves. The authority failed to carry out this duty. In the past, as a resident of a care home, one individual had been able to accrue several hundred pounds in savings. While on guardianship the person accrued over £3,000 of debt.

53. Guardianship includes the power to ensure that the individual does not live in surroundings or with people that represent a risk to him/her. Four of the victims in this case are currently residing in the protected environment of care homes. This outcome, however, occurred only following disclosure of extreme and life threatening levels of abuse and neglect. Timely applications for guardianship, based on comprehensive, multi-disciplinary risk assessments and active care plans could have resulted in an effective level of protection at a much earlier stage.

54. A recurring theme throughout the history of the case, and one that persisted into 2002, is the view that if an allegation is withdrawn or does not result in criminal charges or a conviction, social work has no locus to act. This attitude fails to take account of social work authorities' duty to assess need, to provide services and to protect, regardless of whether criminal behaviour has been established in accordance with a criminal standard of proof. The vast majority of protection services are provided either on a voluntary basis or, when necessary, within the Children's Hearing system or under guardianship.

55. Sexual abuse allegations are very often retracted, particularly when the complainant is put under pressure, is not offered effective support, remains in the same household as the abuser and does not feel that protection will be provided as a result of the allegation. Social work staff showed insufficient understanding of this dynamic of sexual abuse. The result of this lack of understanding was ill-informed assumptions about the truth of the allegations and a failure to base service provision on a comprehensive assessment of need and risk in relation to each incident or allegation.

56. Three of the individuals in this case made very serious allegations of sexual abuse against a number of people. However, they either were considered to be unreliable witnesses by social work and the police, or they routinely withdrew their allegations, sometimes under pressure from people close to them. These retractions were not explored by social work or the police, even when it became apparent that a clear pattern was emerging. Instead the response was that no further action could be taken.

57. Charges were brought against one alleged abuser in 1993, following allegations against him. These charges were dropped in 1994, due to a problem with the evidence. On 7 June 1994, a social worker wrote to the alleged abuser saying: *"I gathered today the case against you wasn't proceeding and that you had gone home. This must be a great relief for you. If you feel that you want to see me again, please get in touch."*

58. In July 1994, further allegations of sexual abuse were made against the same individual. These were not acted upon by social work because they considered there was no basis for statutory intervention. The reasons for this decision were the alleged victim's unwillingness to make a formal complaint and social work's belief in the individual's capacity to make informed decisions. The basis on which social work assessed the individual as able to make decisions is surprising given assessments by health professionals and educational psychology services at various stages. The individual's unwillingness to make a complaint to the police was not sufficient reason for social work not to address the risk posed under the circumstances known to them at the time.

59. By 1998, the risk that one of the offenders posed to young children was formally acknowledged. The department acted appropriately in seeking to protect young children from him. However, this action did not extend to consideration or management of the risk that he posed to very vulnerable adults. This is a critical omission, given that the standard of proof for applications for guardianship in the Sheriff Court is the same as that for the protection of children in the Children's Hearing system.

60. Until March 2002, there is very little evidence of effective engagement with and involvement of service users in their needs and risk assessment, service provision, case conferences and reviews; and no consideration of the importance of their contribution to plans for themselves. This is despite the fact that from before the age of ten one individual tried repeatedly to tell of the abuse she was experiencing. Prior to March 2002, with no opportunity to tell her story in private, the individual had withdrawn all of her allegations.

61. The management arrangements for this case fell short of standards required by the Council locally, by national guidance and by the Scottish Social Services Council Codes of Practice.

62. Although not expressed as standards, there are numerous Scottish Borders Council policy and procedural documents that articulate clearly the expectations on staff for service delivery, for recording, and for supervision and management, including staff discipline. Virtually none of the standards in any of these areas was met in this case.

63. Managers' responsibilities for quality assurance, performance monitoring and control were all largely ignored. Without these, policy and procedures became irrelevant.

64. Formal supervision of frontline staff was infrequent, unstructured and often poorly recorded. There is no evidence of issues of risk being discussed in a constructive way, with no clear expectations on social workers and no evidence of follow-up by managers.

65. None of the requirements of the Council's community care procedures was met. Procedures included criteria for prioritisation of cases. This case met all the agreed criteria for high priority/urgent cases and yet none of the operational procedures for such cases was applied.

66. Procedures included the requirement for detailed community care assessments that are multi-disciplinary and comprehensive, that involve service users and that form the basis of detailed care plans that are regularly reviewed. None of these requirements was met.

67. Procedures required that the protection of vulnerable adults be treated with the same urgency as the protection of children. Despite repeated allegations of serious sexual abuse against several very vulnerable adults, no proportionate responses occurred.

68. There was no clarity of roles and reporting responsibilities for a highly complex case that spanned child care, criminal justice, community care, health and police; no co-ordination of information; and no authoritative link to key external agencies. The lack of understanding of the importance of case co-ordination within the department and across agency boundaries is evident from the case files. This is despite a 30 year history of child death inquiries, each one emphasising the need for better information-sharing.

69. Disproportionate reliance by both frontline staff and managers was placed on individuals who were considered to have expertise in certain fields. One social worker was considered by management to have expertise in learning disability services. In 1995/1996 the social worker participated in Mental Health Officer training but did not attain a satisfactory standard and was not given the award. Other than this training, the social worker's staff development record from 1994 shows attendance at fewer than 6 training days, 3½ of which were in respect of IT or team development. In view of this and of the staff member's disciplinary record (discussed below), it is not clear on what basis the judgement about this expertise was made.

70. Two of the department's Mental Health Officers were involved in this case. Both were considered to have particular expertise. One was the staff member with responsibility for procedural matters in respect of mental health legislation. Their lack of understanding of the provisions of guardianship and of its potential usefulness is explored above. It suggests that the value of their expertise was limited. A contrary view on guardianship to that held by these staff members was expressed by various health professionals at different stages in the case. There was, however, no mechanism for resolving differences of opinion, either within the department or between agencies, and therefore critical decisions were made without the benefit of expert consideration.

71. There was considerable debate during 2002 and 2003 about how much detail of the case was known to which managers on what dates between December 2001 and March 2002. The case histories indicate that various middle and senior managers knew much relevant information from their involvement with the case over several years. A senior manager in December 2001 had chaired a case conference in respect of one individual in May 1984 and had been a member of the case conference in September 1984, which discussed allegations of sexual abuse of another individual. This person was the probation officer for one of the abusers in 1989. Another senior manager with overarching responsibilities in December 2001 had been a senior manager in the children and criminal justice service when the case was made to remove a child from the care of his parents due to the risk posed by one of the alleged abusers. This staff member had also chaired the Adoption Panel that recommended the child's freeing for adoption.

72. Irrespective of their knowledge of individual cases, there is considerable evidence that senior staff's main management and leadership responsibilities were neither understood nor discharged effectively in this case. There is no indication of the promotion of a culture of individual professional responsibility, or of the creation of an organisational framework of quality assurance to underpin individual responsibility.

73. The overall impression given by the facts of this case is of unco-ordinated, ill-informed frontline staff, being given little sense of direction, expertise, challenge, control or support by managers at all levels in the department. This highlights serious questions about the social work service at every level, from individual social workers' practice, knowledge and development – through management standard-setting, supervision and monitoring – to leadership and shaping of organisational culture.

74. The case review carried out by David Stallard following one individual's hospitalisation in March 2002 commented on the high caseloads carried by social work staff and identified this as a contributory factor to the failings in this case. However, examination of case lists suggests little prioritisation of allocations, with a high number of cases listed as active, but with little indication of input from social work staff. This finding was confirmed by a senior manager in a statement to social work consultant Anne Black on 7 January 2003, which indicated that the high caseloads were not an accurate reflection of workloads.

75. The Council could and should have taken other action on repeated occasions in order to respond effectively to the concerns that had been evident throughout the history of this case.

76. The remit of this report does not extend to an examination of the health services provided in this case. This is the subject of an inquiry by the Mental Welfare Commission. It is clear, however, that there was a failure of co-operation at front line level; a lack of operational management liaison; and an absence of joint strategic service planning and standard setting at the most senior level between the agencies.

Question 3: Do Scottish Borders Council's decisions on managerial and personnel issues in relation to this case meet the standards required by the Codes of Practice for social service employers and employees?

77. Section 53 of the Regulation of Care (Scotland) Act 2001 requires the Scottish Social Services Council to publish Codes of Practice, approved by Scottish Ministers, that articulate the accountability and standards of professional practice for social service workers and their employers. They set out their respective responsibilities to protect the interests of services users and carers, to provide high quality services and to promote public trust in social services.

78. Employers' responsibilities include effective:

- recruitment and selection, including the provision of reliable references
- implementation and monitoring of relevant policies and procedures
- training and professional development for staff
- systems for employees to report unacceptable behaviour and practice
- management of poor performance
- support for staff to enable them to comply with the requirements of the codes

79. The Code of Practice for employers emphasises that effective management and supervision of staff, supporting good practice and managing performance are key requirements of social work employers.

80. There is evidence of ineffective management of poor performance of one of the social workers involved in this case. Although the following example is in respect of only one individual's poor performance, the seniority of the managers involved raises concerns about the consistency with which this approach may be applied across the department.

81. Despite staff, service users and external agencies expressing numerous concerns over a period of many years, one social worker continued to practice under limited and ineffective supervision.

82. The person qualified as a social worker in 1986 and was appointed to a social worker post with Borders Regional Council in 1994. From 1995, supervision records include written communication to the social worker from various managers raising a number of concerns about both behaviour and practice. These concerns are repeated at regular intervals throughout the years of the social worker's employment, and include:

    - unauthorised absences from the office and unknown whereabouts
    - unavailability when on duty
    - lack of appropriate response to service requests
    - knowingly leaving clients at risk
    - poor attitude towards service users and staff from other agencies
    - failure to keep up-to-date records of work with service users

83. On at least two occasions, complaints from service users about the social worker's attitude towards them were upheld to the extent that a change of social worker was agreed (1996 & 1997).

84. In September 1998, the report of an investigation into a formal complaint from a service user recommended that supervision be used to address concerns about the social worker's inappropriate actions. There is no evidence in the supervision records of this recommendation being implemented.

85. On 16 March 1999, the social worker failed to make arrangements to cover the care needs of a vulnerable person when notified that the person's home carer was unavailable for work. This inaction resulted in the severe discomfort and distress of the individual. The matter was addressed by means of a memo from a manager to the social worker. No other action was taken.

86. The social worker was the subject of a disciplinary hearing held on 30 June 1999. The case relates to a complaint made by a voluntary organisation about the social worker's conduct at a review meeting on 12 March 1999. The minutes of the hearing are hand-written and undated. The conclusion of the hearing was that this was a serious complaint, but that no disciplinary penalty would be used. The concerns about practice and attitude were to be addressed through supervision and further training; the detail of this is not set out. The Council's

training record shows no training given to the social worker in relation to this issue, and the supervision file shows no record of these issues having been addressed.

87. On a further two occasions in 1999 (July & November), written concerns were expressed by management to the social worker about poor judgement and failure to respond to requests for social work involvement.

88. There is a reference on 12 June 2000 to 2 cases relevant to this investigation having transferred to the social worker in January 2000, but that there had been no contact due to pressures of work. The supervision note from January 2000 by a senior social worker states that contact must be made as soon as practicable. On 17 July 2000, the supervision note indicates no discussion of the cases, indicating no follow-up from the previous comment. There are further supervision notes on 28 August 2000, 25 September 2000 and 6 November 2000, none of which mentions the cases. On 11 December 2000, reference is to ongoing monitoring. There are further supervision records dated 26 February 2001, 5 April 2001, 31 May 2001 and 20 July 2001, none of which makes any reference to these cases.

89. A part-time, temporary senior social worker was appointed in March 2001. The post holder was at that time the effective guardian of one of the individuals in this case. The duties of the post included supervision of social work staff, and should have included responsibility for the social worker described above. However, the post holder made it a condition of acceptance of the post that another manager would take on this responsibility. In statements to the independent inquiries in 2002 and 2003, the post holder gave the following reasons for their refusal: the social worker's reputation within the department for being difficult to manage; their own relative inexperience of management; the temporary nature of the appointment; and the expectation that they would maintain a caseload.

90. There is no record of how or whether the social worker was notified of the arrangements for supervision. A full-time senior social worker retained this responsibility until their move to another post in September 2001, following which supervision of the social worker was passed to a more senior manager. There are no records of any supervision sessions between the social worker and the manager. During this time, the social worker was the allocated worker for 3 of the individuals in this case.

91. On 11 February 2002, following a number of referrals expressing concern about these same 3 individuals, the social worker attended their first supervision session with a newly appointed full-time senior social worker. This was the morning prior to a departmental meeting called to consider the case. The supervision record makes no reference to the social worker reporting any concerns about the case to the senior.

92. On 7 March 2002, following the admission to hospital on 1 March of the individual at the centre of this case, the social worker was suspended on full pay, on the basis of the following concerns, only one of which relates to this case:

    - not responding when on standby; having been informed of a need for cover and doing nothing about it (alleged incident 21 November 2001); this is only one of a number of recorded incidents of a similar nature – see above

    - allegation that following a request for home care cover being refused, the social worker contacted the home care assistant and tried to get her to work privately (alleged incident 5 March 2002)

- cancelling staff shifts without authority and re-arranging these, giving instructions to staff that went beyond the social worker's remit (alleged incident 13/14 February 2002)

- exercising poor professional judgement in working with two vulnerable clients (this case)

93. The social worker's suspension was rescinded by a senior manager in April 2002, prior to the completion of the disciplinary investigation.

94. The recommendation of the disciplinary investigation report writer was that a disciplinary hearing should be held in respect of the social worker having left very vulnerable clients at risk by not arranging cover for their home carer's absences. In respect of the other matters, the recommendation was that these should be dealt with *"on an informal basis through supervision and personal development processes"*. The decision of the senior manager was not to hold a disciplinary hearing in respect of any of the complaints, but to address all of these via supervision and staff development.

95. The department does not appear to have complied either with its own standards or with the Code of Practice in respect of managing performance. The routine outcome of complaints against this social worker was to address their behaviour through supervision, rather than proceed to a disciplinary investigation. When complaints did proceed to a disciplinary hearing, the routine outcome was also to address their behaviour through supervision rather than impose a disciplinary penalty. Supervision records are sporadic, poorly recorded and show long periods during which the social worker received no supervision at all (notably between July 2001 and February 2002). There is no indication of any kind that any of the complaints against the social worker were addressed in supervision.

96. On 20 May 2002, a manager provided an employer's reference for this same social worker who had applied for a social work post with another local authority. The reference was positive and did not comment on any of the concerns in respect of the social worker's practice.

97. On 30 October 2003, a senior manager provided a positive employer's reference for the social worker.

98. Senior managers in the department were fully aware of the social worker's record of poor practice. Having clearly identified this poor performance, they failed to address it through any of the means available to them – supervision, training or discipline. Having failed to address the difficulties this practice represented to the department and the service, they considered it appropriate to support the appointment of this staff member by other organisations, without reference to any areas of weakness.

99. These actions are in breach of the Scottish Social Services Council Code of Practice for employers, which includes: *"effectively managing and supervising staff to support effective practice and good conduct and supporting staff to address deficiencies in their performance (section 2.2);…managing the performance of staff and the organisation to ensure high quality services and care (section 1.5)*…[and] *Seeking and providing reliable references (section 1.3)."*

100. None of the above reflects the personal accountability of senior staff, or the management and leadership expectations that are an integral part of the profession of social work. Each example represents a breach of the employers' Code of Practice.

101. Responsibility for the quality of social work practice does not rest with employers alone. Personal accountability is an essential element of any profession – essential because of the nature of the task. Social workers are depended upon to make critical decisions about the safety and liberty of vulnerable individuals, decisions that will inevitably have significant long-term implications. Scottish Ministers established the Scottish Social Services Council and required the publication of Codes of Practice to emphasise the degree of commitment and professional integrity that is required of high quality social work practice.

102. The Code of Practice for employees includes the following responsibilities:

- protecting and promoting the rights and interests of service users
- respecting confidentiality and confidential information
- reporting unsafe or poor practice by colleagues
- assessing the risk of harm to service users and contributing to the management of such risks
- behaving in ways that uphold public trust and confidence
- being accountable for the quality of their work and taking responsibility for improving their knowledge and skills

Question 4: Does Scottish Borders Council's Action Plan provide for changes in policy and operations that may be reasonably expected to prevent, so far as reasonably practicable, any recurrence of the failings in this case?

103. In 2002, the department commissioned an independent review of the case by David Stallard. Two further reports were subsequently commissioned, one from social work consultant Anne Black and one from Tayside Health Board chairman Peter Bates. Neither the Stallard nor the Black report considered the case histories prior to December 2001. The Bates report focused on current service provision and future plans. Each report made a number of recommendations for improvement action.

104. The department's community care action plan was revised to incorporate the recommendations of the Stallard report. It focuses mainly on the development or review of policies and procedures. It is clear, however, that the failure to support and protect the vulnerable individuals in this case did not occur because of an absence of policy and procedure. Although many of the procedures that existed throughout the history of this case are out-dated by today's standards, they remain sufficiently robust to have provided much more effective protection had they been followed. The failures occurred due to a combination of non-compliance with procedures and of substitution for these of flawed understanding and knowledge; a lack of professionalism; and a lack of effective management and leadership.

105. References to training in the action plan tend to focus on staff awareness of new procedures. It is important for staff to be familiar with the procedures that frame their work. However, this investigation has identified some of the critical gaps in staff's understanding of their role and their knowledge-base. The confusion that both front line and more senior staff demonstrated in respect of guardianship and other forms of statutory intervention was a significant failing in this case, and could be addressed more specifically in the action plan. The commissioning of a leadership and change management course from Stirling University during 2002/2003 is a positive development.

106. The action plan makes no recommendations on multi-agency case co-ordination, information-sharing or joint working in complex, high risk cases. The plan does refer to the proposed implementation of inter-agency guidelines for protecting vulnerable adults. These guidelines allow for individual judgements to be made about multi-disciplinary planning meetings, however, they do not systematise senior level case co-ordination and information-sharing, nor do they set out a mechanism for the identification and resolution of disputes between partner agencies in relation to intervention. Both of these issues were serious failures in the management of this case.

107. In addition to concerns that the action plan may not be sufficiently comprehensive to address all of the failings highlighted by this case, it is difficult to quantify or qualify progress on the plan's recommendations from its layout. The plan was reviewed in June and November 2003. The reviews suggest significant slippage on the original timescales.

108. In October 2003, Scottish Borders Council approved a further action plan, based on the recommendations of the Black report and the Bates report. These recommendations emphasised the need for clarity of communications and for an organisational structure that facilitates the effective discharge of senior management's responsibilities for the quality of service delivery. It is too early to comment on the Council's implementation of this plan. The plan does make reference to the need to draw staff's attention to the requirements of the Scottish Social Services Council Code of Practice for employees, and indicates that staff will be sent a reminder letter in January 2004 about the need for compliance. The Council has produced a timetabled plan for its compliance with the Scottish Social Services Council Code of Practice for employers. The plan addresses the responsibility to *seek* reliable references, however, it should also articulate the responsibility to *provide* reliable references, as per the Code.

109. The need for an emphasis on leadership, communication and involvement rather than on policy and procedure is reflected in a European Framework for Quality Management assessment of 2002/2003 that highlighted a significant number of areas for improvement. A few examples include the need for: a recognition of the distinction between leadership and management; an improvement in the quality of training, linked to skills required; more proactive work with partners, integration of services and joint working; better monitoring and measuring of processes; development of customer feedback; better analysis of complaints; improved performance management; standardisation of staff supervision.

110. The commissioning of external reports can provide a valuable independent perspective, but is not a substitute for managerial examination of and responsibility for the failures of a service. The future of the service cannot rely on external consultants or on the further development of policy and procedure. Ownership, at all levels, of the personal responsibility to act professionally and in accordance with expected standards of practice is a critical feature of the recovery of the service.

111. Neither should the revision of policy and procedure be the mainstay of the department's recovery plan, without strong emphasis on attitudinal change – from frontline staff to the most senior managers – and without clarity of professional responsibility, effective quality assurance systems and an empowering organisational culture.

112. In reviewing progress on its action plan the Council should address the additional points outlined above.

Question 5: Are there lessons for wider application across social work services in Scotland?

113. The recommendations that follow include actions for all councils and actions that will have an impact on all councils.

SECTION II: RECOMMENDATIONS

114. This section does not repeat the recommendations from earlier reports (David Stallard, Anne Black and Peter Bates) that are covered in Scottish Borders Council's Community Care Action Plan and an associated action plan. It is important that these action plans are fully implemented and that the implementation is closely monitored by the Council.

115. Recommendations 1 and 2 below relate specifically to action that should be taken by the Council in respect of the individuals involved in this case. Recommendations 3 to 23 relate to management action required of the Council in respect of service delivery. These will be of interest to other Scottish local authorities in their examination of their own service provision. Recommendations 24 to 28 are for consideration by the Scottish Executive.

116. Where necessary, recommendations are preceded by explanatory text, emphasising the reasons for the recommendations.

117. During the inspection, it became clear that a number of recommendations should be made in respect of the service users involved in this case, and that these should not await the finalisation of the report. On 6 October 2003, the Chief Social Work Inspector asked Scottish Borders Council to address the following issues for each individual:

- criminal injuries compensation – the lengthy delay in progressing claims on behalf of individuals who may have an entitlement
- independent advocacy – the absence of a service for any of the individuals
- the need for independent legal representation for the individuals
- occupational and speech therapy – the need for up-to-date assessments or action in respect of recent assessments
- communication devices and their best use for those individuals who depend heavily on these, but who may not currently have the most appropriate equipment
- family contact – the need to facilitate this at higher levels than was the case, in accordance with the wishes of the individuals

118. Scottish Borders Council responded promptly to this request, however, a number of issues remain outstanding.

Recommendation 1:
The implementation of the recommendations contained in the Chief Social Work Inspector's letter to the Chief Executive of Scottish Borders Council dated 6 October 2003 should be continued.

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119. The protection of finances of all those who were exploited in this case was never properly considered. Local authorities have a clear statutory duty to take action to protect the finances of people with a mental disorder unable to do so themselves. The Council failed to carry out this duty. The Council's responsibilities are not mentioned in departmental guidelines on mental health legislation. They are mentioned in Section 4.3.4 of the Council's Vulnerable

Adults Guidelines, however, their interpretation is that this duty applies only where a person with a mental disorder has a great deal of property that requires to be managed, or where it is necessary to sell or recover property on behalf of a person with a mental disorder.

120. Local authority responsibilities were re-emphasised in the Scottish Executive Circular CCD2/1999: "Protection of the Finances and Other Property of People Incapable of Managing their Own Affairs", which states: *"where there is doubt about an individual's capacity to manage their affairs, and appropriate formal arrangements have not already been made, professional psychiatric and legal advice should be sought"*. There is no evidence in any of the case files that this was ever undertaken in a concerted, focused manner aimed at developing a plan to protect individuals' finances or property.

121. The local authority failed to protect the finances of one individual to the extent that the person accrued some £3000 of debt whilst subject to guardianship.

Recommendation 2:
Scottish Borders Council should consider making financial restitution to the individual concerned for these debts.

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122. Scottish Borders Council has incorporated the recommendations from the Stallard report into its action plan for community care. The Council has also agreed an action plan that addresses the recommendations of the Black and Bates reports. These plans focus heavily on the development or review of policy and procedure. Up-dated policies are an important element of service delivery. However, the identified failures in this case were not caused by the absence of policy and procedure, but by a lack of knowledge and understanding of the social work task and its statutory framework, at both frontline and more senior levels. The lack of both management and leadership was also a critical factor.

123. The Council has a responsibility to ensure that individual professional responsibility is held and acted upon; that sound management arrangements are in place; and that leadership is promoted to identify difficulties and develop solutions. These qualities should form the basis for the recovery of the service, rather than a reliance on the existence of a procedural framework.

124. The Scottish Social Services Council Codes of Practice articulate clearly the expectations on both social service workers and their employers, and provide the framework for the required organisational changes. The Codes are approved by Scottish Ministers. The Code of Practice for social service workers describes the standards of professional conduct required of staff who must:

- protect the rights and promote the interests of service users and carers
- strive to establish and maintain the trust and confidence of service users and carers
- promote the independence of service users while protecting them as far as possible from danger or harm
- respect the rights of service users whilst seeking to ensure that their behaviour does not harm themselves or other people

- uphold public trust and confidence in social services, and
- be accountable for the quality of their work and take responsibility for maintaining and improving their knowledge and skills

125. The Code of Practice for employers sets out the responsibilities of employers in regulating social service workers, in order to protect and promote the interests of service users and their carers. Employers must:

- make sure people are suitable to enter the workforce and understand their roles and responsibilities (this includes seeking and providing reliable references)
- have written policies and procedures in place to enable social service workers to meet the Scottish Social Services Council (SSSC) Code of Practice for Social Service Workers
- provide training and development opportunities to enable social service workers to strengthen and develop their skills and knowledge
- put in place and implement written policies and procedures to deal with dangerous, discriminatory or exploitative behaviour and practice, and
- promote the SSSC's codes of practice to social service workers, service users and carers and co-operate with the SSSC's proceedings

126. Scottish Borders Council agreed a timetabled action plan for its compliance with the Code of Practice for employers in August 2003. The plan sets out the requirements of the Code and the Council's proposed actions, but makes no reference to the improved outcomes that the Code is intended to support. There is no link between the mechanics of the action plan and the changes in organisational behaviour that the Code seeks to promote. The action plan is silent on employers' responsibility to provide reliable staff references to other organisations.

Recommendation 3:
Scottish Borders Council should review the implementation of its action plan for compliance as an employer with the Scottish Social Services Code of Practice to ensure that it covers all the requirements of the Code and to ensure that implementation will secure the necessary changes in organisational behaviour described in this report, that are intended by the Code and that are essential to the effective functioning of the Department of Lifelong Care.

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127. The department relied on assumptions about the expertise of staff in certain areas, notably services for people with learning disabilities and guardianship. These assumptions were not supportable in respect of some staff, in the light of their known performance and of departmental training records. Whilst there are clear benefits in maximising the use of expertise internally, it is essential that the basis of this expertise is sound.

128. Local guidance and procedures available to staff in respect of mental health legislation included:

- *A Guide to Social Work Services in the Mental Health Unit* (issued 28/09/95)
- *Duties of Mental Health Officers* (derived from Tayside document but undated)
- *Guardianship* (derived from Tayside document and issued 04/02/91)
- *Guidance on Guardianship* (issued 12/03/01)

129. There is very little consideration in any of these documents of the complex legal, ethical and professional practice decisions that need to be made before the legislation is implemented. The material focuses on explaining various sections of the legislation and their practical implementation by staff.

130. Effective discharge of the statutory responsibilities conveyed by the Mental Health (Scotland) Act 1984, the Adults with Incapacity (Scotland) Act 2000 and, when implemented, the Mental Health (Care & Treatment) (Scotland) Act 2003 will require more than the development of up-to-date procedures and bringing these to the attention of staff.

131. The lack of understanding among staff, including Mental Health Officers, of the role of statutory intervention is a characteristic of this case that contributed to the serious delay in protecting a number of very vulnerable individuals. The flawed judgements that are articulated repeatedly in the case recording require to be addressed. References to staff development in the Council's agreed action plans centre on training staff in the implementation of new or revised procedures, rather than on social work issues. For example, there is no focus on how staff need to balance the demands of protection and risk management with issues of inclusion and self-determination.

132. During the period under consideration, there was only very infrequent use of guardianship, and there was evidence in this case that when guardianship was used it was ineffective. There has been a positive increase in Scottish Borders Council's use of guardianship over the past two years. This needs to be paralleled by staff's understanding of how its use can provide for the protection of vulnerable individuals.

Recommendation 4:
The Department of Lifelong Care should review the expertise of Mental Health Officers operating in management positions and in all service areas to ensure they have up-to-date knowledge of relevant legislation, particularly as it relates to learning disability, issues of capacity and the protection of individuals and property. Without a more rigorous, formalised approach to the assumption of staff's expertise, this should not be relied upon for critical decision-making.

Recommendation 5:
Staff development programmes should include a focus on the complexities of adult protection; the role, purpose and thresholds for statutory intervention; and the duties that are extended and reinforced in the Adults with Incapacity and the Mental Health (Care & Treatment) Acts.

Recommendation 6:
The Department of Lifelong Care should develop a system of regular refresher training for Mental Health Officers and should ensure that staff are aware of how to access specialist advice and guidance, including legal advice.

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133. Effective implementation of relevant recommendations from the Council's action plans (review of prioritisation of cases, improved recording, information-sharing and monitoring, application of community care procedures) and implementation of the multi-agency guidelines on protecting vulnerable adults will apply essentially to new cases.

134. This case had been open to social work since the early 1970s with no considered re-assessment of risk or need. Only formal re-appraisal can provide the evidence that other similar cases do not exist.

Recommendation 7:
The Department of Lifelong Care should carry out a review of all cases of adults with learning disabilities to assess the level of risk and determine the quality of service. The department should consider the level of seniority of staff conducting the review and may wish to commission the review from an independent source. The department should use a checklist for this review to ensure a consistent approach across all cases. The checklist should include (but not necessarily be restricted to) the following critical questions:

- **Is there an allocated social worker with the necessary skills and experience to work with the complexities of this case?**
- **Has all the relevant information been gathered from departmental files, other departments, police, health and other involved sources?**
- **Is there a chronology of significant events and are the implications of these events understood?**
- **Is there a comprehensive assessment of risk and need?**
- **Is there evidence that the experiences of family members have been taken into account when assessing risk?**
- **Is there an appropriate care or protection plan that is being effectively implemented and that is demonstrably reducing the assessed risk?**
- **Has statutory intervention been considered and are the decisions in respect of this correct?**
- **Are copies of all minutes and records of decisions in the case file; have these been circulated to relevant individuals; and are the case records up-to-date?**
- **Is there evidence that the individual is being seen and spoken to on their own on a regular basis by the allocated social worker (where necessary using an interpreter or appropriate communication device); and have their living arrangements been seen?**

- **Is there evidence of good communication and collaboration between social work services, e.g. community care, criminal justice and children's services, and between social work and other key agencies, e.g. health, police, housing, education?**

- **Has the case been reviewed in accordance with procedure and has the individual been supported in contributing effectively to the review?**

- **Is there evidence that the social worker's handling of the case is subject to oversight by his/her line manager?**

The results of the review, together with any proposals for remedial action, should be reported to elected members of the Council by the Chief Social Work Officer.

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135. The vulnerability of adults with learning disabilities and their right to effective protection were not given sufficient priority by the department. Individuals subject to guardianship or to repeated, serious allegations of neglect and abuse were engaged with only at a very superficial level. They were rarely seen in their home environment and were not given an opportunity to express their views and wishes. Social workers were left to make decisions and judgements about priority, criteria for intervention and level of service that were ill-informed and that were neither monitored nor challenged.

Recommendation 8:
All allegations of harm or neglect of people with learning disabilities should be allocated to a social worker. Managers allocating cases must be clear as to what has been allocated, what action is required and how that action will be reviewed and supervised. Supervision arrangements should include formal case management, with all decisions clearly recorded by the supervisor and monitored at regular intervals.

Recommendation 9:
People with learning disabilities who are the subject of allegations of deliberate harm (regardless of the source of the allegations) must be seen and spoken to alone or with appropriate support within 24 hours of the allegations being communicated to social work. The individual's living arrangements should be seen. If this timescale is not met, the reason for the failure must be recorded on the case file and countersigned by a manager. This requirement should apply irrespective of whether the case is known to the department.

Recommendation 10:
In cases where concerns have been expressed about the safety of a person with learning disabilities (regardless of the source), social workers undertaking home visits should be clear about the purpose of the visit, the information to be gathered during the course of it, and the steps to be taken if no-one is at home or if access is denied. Other than in emergencies, visits should not be undertaken without the social worker concerned checking the information known about the individual by other agencies.

Recommendation 11:
All allegations of harm or neglect of people with learning disabilities must be subject to a risk assessment. All risk assessments, and any protection plans drawn up as a result, must be approved in writing by the social worker's line manager. Before giving such

approval, the manager must ensure that the individual has been seen and spoken to alone or with appropriate support. A senior manager should routinely consider a random sample of risk assessments and associated protection plans.

Recommendation 12:
The accommodation and living arrangements of any individual subject of allegations of abuse must be monitored and reviewed by the allocated social worker. Unsuitable arrangements must be reported to a line manager.

Recommendation 13:
All case conferences, case reviews, meetings and discussions concerning people with learning disabilities should involve the following four basic steps:

- **a list of action points must be drawn up, each with an agreed timescale and the identity of the person responsible for implementation**
- **a clear record of the discussion must be circulated to all those invited, whether or not they were present, and to all those with responsibility for an action point**
- **a mechanism for reviewing completion of the agreed actions must be specified, together with the date upon which the first such review is to take place**
- **any supplementary actions that may be required as a contingency in the event of a breakdown in care arrangements or other changes in circumstances**

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136. The facts of this case indicate little preparation or planning for the conduct of interviews with the individuals subject to alleged abuse, all of whom had a degree of learning disability, and two of whom had severe communication difficulties. Individuals were either not interviewed at all, were seen in the presence of the alleged perpetrator, or were seen on an ad-hoc basis – on the pavement or in the social worker's car.

Recommendation 14:
The interview of people with learning disabilities subject to alleged abuse should be formally planned. Planning should include consideration of a safe environment; the use of interviewers with the necessary skills and understanding; the emotional support needs of the individual; and the use of necessary communication aids or an interpreter. The interview should be recorded in detail, using the individual's own words.

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137. An important characteristic of this case was the aggressive response from key figures to social workers' attempts to enquire into expressions of concern about certain individuals. Intimidation and the fear of violence contributed to the lack of effective intervention by social workers to protect individuals from harm. Unfortunately such intimidation and fear are routine factors in the field of protection, but they cannot be allowed to compromise the level of service offered to very vulnerable individuals who rely on the capacity of agencies to withstand these pressures on their behalf.

Recommendation 15:
The Department of Lifelong Care should ensure that where the investigation of allegations of abuse may be impeded by the threat of violence to staff, staff are

effectively protected and supported in carrying out their task. This could include visits being carried out in pairs, or involvement of the police where appropriate.

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138. There was insufficient management overview of the quality of social workers' assessments and judgements and of service levels. There was poor management follow-up of referrals from the out-of-hours service to the allocated social worker. There was a lack of knowledge or understanding of the degree of risk to which service users were subject, and there was little responsibility taken for assuring the quality of the service generally.

Recommendation 16:
The Department of Lifelong Care should devise and operate a system that enables managers to establish immediately how many vulnerable people have been referred to their out of hours service, what action is required for each referral, who is responsible for taking that action, and by when that action must be completed.

Recommendation 17:
The Department of Lifelong Care should ensure that senior managers inspect, at least once every three months, a random selection of case files and staff supervision notes.

Recommendation 18:
The Department of Lifelong Care should monitor the effective implementation of its procedures relating to the transfer of cases between teams or services within the department.

Recommendation 19:
The Department of Lifelong Care should ensure that no open case that includes allegations of deliberate harm to a vulnerable adult is closed until the following steps have been taken:

- **the individual has been spoken to alone**
- **the individual's accommodation has been visited**
- **the views of all relevant professionals have been sought and considered**
- **there is evidence that the individual's welfare will be safeguarded and promoted should the case be closed**

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139. Scottish Borders Council, together with neighbouring local authorities, NHS Lothian, NHS Borders and Lothian & Borders Police, has approved multi-agency guidelines on protecting vulnerable adults. These were due to be implemented in October 2003. The guidelines are silent on the matter of resolving disagreements between agencies on the need for intervention. The guidelines make only minimal reference to the need for a senior social work manager to *"liaise with senior members of staff and/or other agencies."* Key failures in the management of this case included the lack of effective information-sharing between agencies; the lack of an identified senior staff member with responsibility to ensure effective liaison between agencies; and the lack of any formal mechanism for resolving differences of opinion among staff from partner agencies.

Recommendation 20:
Scottish Borders Council, together with its partners in NHS Borders and Lothian & Borders Police, should ensure multi-agency and multi-disciplinary co-ordination of complex cases at a sufficiently senior level to provide appropriate management oversight, effective information-sharing and accountable practice. Arrangements should include a mechanism for the articulation and resolution of disputes between staff.

Recommendation 21:
The Department of Lifelong Care should ensure that when a referral concerning the well-being of a vulnerable adult is received from a professional, the fact of that referral is confirmed in writing by the referrer within 48 hours, and a written acknowledgement issued to the referrer by social work staff.

Recommendation 22:
The Department of Lifelong Care should ensure that when a professional from another agency expresses concern to the department about its handling of a case, a senior manager reviews the file, meets and speaks to the professional concerned, and records in the case file the outcome of the discussion.

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140. In August 2002, Scottish Borders Council issued a *"Whistle Blowing"* policy to all employees. The intention of the policy is to expect and assist staff to report to senior managers concerns about practice, without fear of intimidation or other negative repercussion. Policies for the reporting of concerns are a necessary baseline for organisations, however, the focus should be on creating a climate of continuous improvement by promoting the blame-free identification of errors, critical incidents and "near misses".

Recommendation 23:
The Department of Lifelong Care should develop a system of regular peer/management review of practice to encourage the positive identification of difficulties within a learning environment, and so promote continuous improvement.

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141. Professional leadership is a critical factor in the provision of high quality social work services and should play a key role in securing credibility and public confidence through public accountability for the quality of professional practice. The statutory role of Chief Social Work Officer should be the repository for the professional leadership and public accountability of social work services.

Recommendation 24:
The Scottish Executive should review the role of Chief Social Work Officer with a view to articulating and strengthening the professional accountability of the position within local authorities for oversight of the quality of services, and the reporting responsibilities of the office to local authorities.

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142. The Scottish Executive published *"The same as you? A review of services for people with learning disabilities"* in 2000. The report recommended that local authorities and the NHS should set up and maintain local databases (registers) of people with learning disabilities. Learning disability databases are one of the workstreams for the Scottish Executive's *eCare*

programme. Local electronic databases will contain information that is shared between the local authority and the NHS. It is important to ensure that staff working with people with learning disabilities are aware of abuse issues and of the need to protect the individual.

Recommendation 25: Local databases of people with learning disabilities should include summarised information on all abuse allegations, whether or not these have been established to the criminal standard of proof.

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143. *The same as you?* recommended that all local authorities, in partnership with health and other agencies, develop local guidelines on protecting vulnerable adults.

Recommendation 26:
A national multi-agency group should carry out an audit of the development and quality of local guidelines for the protection of vulnerable adults, and based on the outcome of this audit, make recommendations to the Scottish Executive as to the need for the development of national guidelines.

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144. The Scottish Executive is considering the need for Vulnerable Adults legislation, with a view to contributing to the protection of people who are at risk of abuse and exploitation.

145. Statutory provisions existed to ensure the protection of the individuals in this case. One of the reasons these provisions were not used was the disagreement between agencies about whether service users met the criteria for guardianship. There was, however, little disagreement as to their vulnerability.

146. Clarification of some aspects of the legislation as it relates to vulnerable people would be a positive development, providing clearer criteria for their protection. The Mental Health and Adults with Incapacity Acts address the needs of people who have a mental disorder or who lack capacity. A Vulnerable Adults Bill would include people with learning disabilities and would also be particularly relevant for other vulnerable people who do not lack capacity and who do not have a mental disorder.

Recommendation 27:
A Vulnerable Adults Bill should be introduced to complement the protective measures that already exist under the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003.

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147. Section 53 of the Regulation of Care (Scotland) Act 2001 requires the Scottish Social Services Council to publish Codes of Practice that articulate standards of conduct and practice expected of social service workers and their employers. Compliance with the Codes of Practice is a condition of social service workers' registration with the Social Services Council. Section 53 (4) of the Act requires employers to "take account" of the Codes of Practice.

Recommendation 28:
Scottish Ministers should reinforce the duty of social service workers' employers in respect of the Scottish Social Services Council Code of Practice.

APPENDIX I

REMIT OF INSPECTION

INSPECTION OF SCOTTISH BORDERS COUNCIL SOCIAL WORK SERVICES FOR PEOPLE AFFECTED BY LEARNING DISABILITIES

TO BE CARRIED OUT BY SOCIAL WORK SERVICES INSPECTORATE (SWSI)

1. To examine and review the quality and effectiveness of all Scottish Borders Council's social work services provided to a number of individuals since their first contact with the Council.

2. To identify whether any failings occurred at a practice, management and system level, based on a review of all the evidence.

3. To determine whether current arrangements are in line with best practice.

4. To report to Ministers, with recommendations for action to be taken by Scottish Borders Council.

5. Ministers will publish the final report, which may include recommendations for wider application by Scottish local authorities.

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