



Investigations into Scottish Borders Council and
NHS Borders Services for People with Learning Disabilities:
Joint Statement from the Mental Welfare Commission
and the Social Work Services Inspectorate



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THE FACTS OF THE CASE

On 1 March 2002, a woman was admitted to Borders General Hospital after she had gone to the house of a friend who found her to be badly injured and called an ambulance. She was taken to hospital with multiple injuries from physical and sexual assault. A police investigation revealed a catalogue of abuse and assaults over the previous weeks and possibly much longer. Three men were convicted of the assaults later in 2002.

The woman was considered to have a learning disability. A series of events had led to her being cared for by one of the convicted offenders. Over many years, there were events and statements in records held by social work, health services and the police that raised serious concerns about this person's behaviour toward this woman.

Other individuals were receiving care under the same circumstances. They had varying degrees of learning disabilities, physical disabilities and mental health needs, which were largely neglected, to the point of becoming potentially life-threatening for some. Health and social work records contained numerous statements of concern about their care, including allegations of serious abuse and exploitation that were not acted upon. From late 2000, the lives these individuals became increasingly chaotic. They were neglected, lived in unsuitable and unsanitary conditions and were financially and sexually exploited.

The people involved had numerous contacts with:

- Social Workers
- General Practitioners
- District Nurses
- The local Learning Disability Specialist Team
- General Hospital Services
- Dieticians
- Police

In June 2003, the Minister for Education and Young People asked the Social Work Services Inspectorate (the Inspectorate) 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.

Within a similar timescale, the Mental Welfare Commission (the Commission) carried out an investigation into the involvement of health services in this case, paying particular attention to joint working between health and social work services.

In order to protect the identities of the individuals involved, the Mental Welfare Commission 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.

Despite the different scope and remit of the Inspectorate's investigation and the Commission's inquiry, the two organisations liaised closely throughout their respective investigations to ensure appropriate information-sharing and avoidance of duplication wherever possible. Set out below is a summary of the main findings of both investigations, followed by their recommendations in full.

THE FINDINGS OF THE INVESTIGATIONS

Listed below are the main findings from both investigations. Although some of the findings are common to both investigations and some are directed at the relevant service, they are listed together to emphasise the importance of joint working in cases such as this one.

- failure to investigate appropriately very serious allegations of abuse
- an acceptance of the poor conditions in which the people involved lived and the chaos of their lives
- lack of comprehensive needs assessments, including carers' assessments, or assessments of very poor quality, despite clear and repeated indications of need from the earliest point of agency contact
- lack of information-sharing and co-ordination within and between key agencies (social work, health, education, housing, police)
- disagreements between agencies at frontline and middle management level, with no mechanism for resolving these
- unsustained contact with the individuals by the specialist Learning Disability service
- failure by some members of the Primary Care Team (GPs and District Nurses) to act on information about poor home conditions and to make these concerns known to the social work service
- lack of risk assessment and failure to consider allegations of sexual abuse
- very poor standards of case recording, falling well below acceptable practice
- lack of care plans identifying the purpose of contact with individuals
- lack of understanding of the legislative framework for intervention and its capacity to provide protection
- failure to consider statutory intervention at appropriate stages
- failure to understand and balance the issues of self-determination and protection
- failure to protect the finances of vulnerable individuals
- inability and/or unwillingness to confront aggression and staff's consequent collusion with aggressors to the detriment of victims
- lack of understanding of the complexities of child/adult protection and of the need to explore all allegations of abuse and the possible reasons for retraction of these
- failure to communicate with service users or to engage them effectively in assessing their needs
- lack of compliance with procedures

- infrequent, unstructured and poorly recorded supervision of frontline staff by managers
- serious deficiencies in training and development
- lack of clarity of roles and reporting responsibilities
- uninformed and inaccurate assumptions of individual staff expertise in particular areas and consequent dangerous reliance on this
- lack of senior management and leadership
- ineffective management of poor practice
- breaches of the Scottish Social Services Council Code of Practice for employers

THE MENTAL WELFARE COMMISSION'S RECOMMENDATIONS

Health and social work services

1. The role and function of the Borders learning disability service should be reviewed to ensure that the service addresses the health needs of persons, including children, with a learning disability. Special attention should be paid to communication and to the clarity of roles and responsibilities within the Team.

We are aware that a review carried out by NHS Borders and Scottish Borders Council is nearing completion with an agreed strategy having been prepared. We support the proposal in the Borders strategy for adults with a learning disability that there should be a single community learning disability service formed from NHS Borders and social work learning disability services with a single manager. Our recommendations would apply equally to a joint service.

2. NHS Borders should provide guidance for staff on roles, responsibilities and communication within primary care services, acute services and learning disability services in cases involving people with a learning disability where there is multi-disciplinary involvement.
3. General practitioners and primary health care services in the Borders should be made aware of and have easy access to information about the needs of people who have a learning disability. Services must be flexible and delivered in a way that recognises and accommodates any special requirements of persons with a learning disability. Appropriate liaison and support from the specialist learning disability services should be in place in line with Promoting Health Supporting Inclusion, NHS QIS Learning Disability Quality Indicators and NHS Health Scotland Learning Disability Needs Assessment Report.
4. NHS Borders, along with its partners in Scottish Borders Council and Lothian and Borders Police, should ensure multi-disciplinary co-ordination of complex cases involving people with learning disability where more than one agency is involved. The co-ordination should be at a sufficiently senior level to provide appropriate management oversight, effective information sharing and accountable practice. Arrangements should include a mechanism for the resolution of case management disputes between staff.

5. The implementation of the Vulnerable Adults Policy in the Borders should be monitored, reviewed and evaluated to ensure that the needs of vulnerable persons with a learning disability are recognised and responded to by Health and Social Work Services and their partners in Lothian and Borders Police. This should take account of recommendation 23 of the "*The same as you?*" report published in May 2000, which states, "the appropriate agencies should develop policies and guidelines on protecting vulnerable adults. Social work departments should review their procedures on guardianship to include making a formal assessment of risk a normal part of deciding whether an application should be made".
6. The discharge policy and procedures of Borders General Hospital should give guidance on the needs of patients who have a learning disability. Liaison arrangements between learning disability services and acute hospital services in the Borders should be in line with "Promoting Health Supporting Inclusion" and the recent NHS Health Scotland Learning Disability Health Needs Assessment Report and NHS QIS revised Learning Disability Quality Indicators (both published on 23 February 2004).
7. NHS Borders and Scottish Borders Council should ensure that all appropriate staff are aware of the importance of informal carers and their rights to a carer's assessment. The Scottish Executive has produced guidance for local authorities, the NHS, voluntary sector and other agencies relating to the implementation of support to carers contained in the Community Care and Health (Scotland) Act 2002 (Circular No CCD 2/2003).
8. NHS Borders and Scottish Borders Council Social Work Services should carry out a review of record keeping for cases where there is multi-agency involvement.
9. A dedicated dietetic service should form an integral part of Borders learning disability services.
10. NHS Borders should review existing policy and provide clear procedures and guidance to medical staff and community nursing staff on the transfer of information between primary health care teams when patients move.

Scottish Executive

11. The Scottish Executive should prioritise the introduction of a comprehensive Vulnerable Adults Bill to the Scottish Parliament.
12. The Scottish Executive should give guidance to all Health Boards and local authorities, in line with recommendation 23 of "*The same as you?*" report, on the use of the Care Programme Approach for people with learning disabilities who have complex needs, whether these needs are caused by disability or vulnerability.
13. The Scottish Executive should produce guidance for health and social work services on how to carry out critical incident reviews in cases where there has been multi-agency involvement with individuals who have a mental disorder.

Other Bodies

14. Regulatory bodies such as NHS Quality Improvement Scotland, Social Work Services Inspectorate and the Care Commission should take account of the findings of this report. Consideration should be given to a joint visit with the Mental Welfare Commission to Borders learning disability services within the next 12 months.

THE SOCIAL WORK SERVICES INSPECTORATE'S RECOMMENDATIONS

Scottish Borders Council

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.
2. Scottish Borders Council should consider making financial restitution to [one] individual [for debts accrued whilst the person was subject to guardianship.]
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.
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.
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.
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.
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.

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.
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.
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.
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.

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.
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 carrying it out
 - 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
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.
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.
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.
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.
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.
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

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.
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.
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.
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.

The Scottish Executive

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

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