

Education, Children and Families Committee

10am Tuesday 7 March 2017

Recommendations of the Social Work Complaints Review Committee of 24 February 2017

Item number

Report number

Wards

All

Links

Coalition pledges

Council outcomes

Single Outcome Agreement SO2

Gerrard Clark

Chair, Social Work Complaints Review Committee

Contact: Lesley Birrell, Committee Services

E-mail: lesley.birrell@edinburgh.gov.uk | Tel: 0131 529 4240

Recommendations of the Social Work Complaints Review Committee of 24 February 2017

Summary

To refer to the Education, Children and Families Committee recommendations of the Social Work Complaints Review Committee on consideration of a complaint against the social work service within the Communities and Families Directorate.

For decision/action

The Social Work Complaints Review Committee has referred its recommendations on complaints against the social work service within Communities and Families to the Committee for consideration.

Main report

- 1 Complaints Review Committees (CRCs) are established under the Social Work (Representations) Procedures (Scotland) Directions 1996 as the final stage of a comprehensive Client Complaints system. They are required to be objective and independent in their review of responses to complaints.
- 2 The CRC met in private on 24 February 2017 to consider a complaint against the social work service within Communities and Families. The complainants and the service representatives attended throughout.
- 3 The complainants remained dissatisfied with the Council's response to complaints about accident and incident handling and reporting procedures in respect of an injury sustained by their daughter at her playscheme service.
- 4 The complaint comprised the following main points:
 - i) the complainants stated that the Council's response to them was inaccurate as she did not receive information on other appropriate community resources;
 - ii) the complainants remained dissatisfied that their daughter was not prioritised by the Consortium for an alternative playscheme. The complainants felt they were being victimised for making a complaint; and
 - iii) the complainants stated that they could not understand how their daughter's broken tooth was not noticed by playscheme staff following the incident.

- 5 The complainants acknowledged that, although they had accepted the apology provided by the Chief Social Work Officer, they felt that the service provided had fallen below the standard expected. It was accepted that improvements to procedures had been implemented and steps taken to ensure this did not happen again.
- 6 The complainants explained they wished to highlight two key areas within the investigation which they felt had not been adequately addressed. Firstly, their daughter had been allocated 1-1 care and they could not accept that over a 2-hour period no-one had noticed her injuries or reported them. Secondly, following the incident and after removing their daughter from the playscheme, the complainants then were neither prioritised nor offered another place in an alternative playscheme for their daughter for a period of time thereafter and she was placed at the bottom of waiting lists.
- 7 The complainants felt that their daughter should have been prioritised for a place within an alternative playscheme due to service failure within the playscheme where the incident had occurred.
- 8 Members of the Committee were then given the opportunity to ask questions of the complainant.
- 9 The Investigating Officer confirmed that the playscheme service for disabled children and young people was a universal and non-assessed service which operated on a first come first served basis. Families chose to book places direct through the service provider and paid a contribution towards the cost of their child attending. The Council was not required to offer a replacement.
- 10 The Investigating Officer advised that the Consortium dealt with a huge range of children with differing levels of disabilities and needs and it was not easy to simply move one child from one service to another. Each child's individual needs required to be risk assessed and children were offered places based on the service's ability to meet those individual requirements.
- 11 The Council had provided the complainants with information on other community resources.
- 12 The Investigating Officer confirmed that the complaint had been upheld by the service provider and that the response to their daughter's accident had been unacceptable. A number of service improvements had been identified by the service as a result of this to prevent a similar issue recurring.
- 13 Members of the Committee were then given the opportunity to ask questions of the Investigating Officer.
- 14 Following this, the complainants and the Investigating Officer withdrew from the meeting to allow the Committee to deliberate in private.

Recommendations

After full consideration of the complaints the Committee reached the following decisions/recommendations:

- 1) The Committee did **not uphold** the complaint set out in paragraph 2.1 of the report by the Acting Executive Director of Communities and Families. However, the Committee felt that more information and explanations could have been given to the family. The Council had provided the information on community options but this did not constitute an equivalent service. Unfortunately there was no equivalent option available through the Consortium.
- 2) The Committee did **not uphold** the complaint set out in paragraph 2.2 of the report by the Acting Executive Director of Communities and Families. The Committee was of the view that whilst the Council did not give the complainants' daughter priority, there was no evidence of victimisation. There was also insufficient evidence available to conclude that prioritisation would have provided a solution to the problem.
- 3) The Committee did **not uphold** the complaint set out in paragraph 2.3 of the report by the Acting Executive Director of Communities and Families. The Committee believed this part of the complaint had arisen from the inadequate assessment and reporting which had been investigated and had been the subject of an apology.

The Committee also noted that the Care Inspectorate report had accepted the improved accident and incident handling and reporting procedure and had not made any further recommendations.

Background reading/external references

Agenda, confidential papers and minute of the Complaints Review Committee of 24 February 2017.

Links

Coalition pledges

Council outcomes

Single Outcome Agreement

SO2 Edinburgh's citizens experience improved health and wellbeing, with reduced inequalities in health

Appendices

None.