Education, Children and Families Committee

10am Tuesday 7 March 2017

Recommendations of the Social Work Complaints Review Committee of 1 March 2017

Item number	8.5.1
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Report

Recommendations of the Social Work Complaints Review Committee of 1 March 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 1 March 2017 to consider a complaint against the social work service within Communities and Families. The complainants and the service representatives attended throughout.

3 The complaint related to the complainant's dissatisfaction with the Council's response to a complaint which comprised the following main points:

i) The complainants remained dissatisfied with the Council's response to their complaint regarding the social work placement of their daughter following her discharge from the Child and Adolescent Mental Health Service, Inpatient Unit (YPU), Royal Edinburgh Hospital. They stated that their daughter had been placed in a Young People's Centre against their wishes, without their consent and that this open unit was a dangerously inappropriate setting given her mental health, self-harming and suicidal behaviour. The complainants did not accept that that social work staff were not aware that the NHS was planning to discharge their daughter from hospital until forty eight hours previously. They disputed that a sound risk assessment was completed and sought further clarity around the discharge process as it occurred, including the Council's challenge of the NHS decision to go ahead with the discharge.

ii) They disagreed with the Council's rationale for refusing their offer to fund specialist care for their daughter in the short term. This was on the grounds that the initial assessment of care needs and risk was sound and that when a young person was first placed away from home local resources should be used rather than ones outwith the authority.

iii) They were dissatisfied with the care planning provided including the lack of written information around their daughter's care and medication needs from the NHS to the Council and the absence of available details describing the information provided by social work staff to staff at the Young Persons Centre. They advised that no additional support had been put in place for their daughter until a week after her discharge when a nurse was allocated. It was further advised that no changes were made to their daughter's care plan until a week after she absconded from the Centre.

iv) They disagreed with the decision of social work not to examine all evidence including information from their daughter's phone and reviewing and revising plans in light of new information. They did not accept that actions taken by social work in examining the available information were reasonable and proportionate.

v) They disagreed that social work reports were of a satisfactory quality, balanced and fair. Further to this they did not agree that factual inaccuracies identified in reports were corrected by social work staff and did not impact subsequent decision making.

vi) They were dissatisfied by the lack of social work review into their daughter's case and believed that no review would have been undertaken had they not submitted a complaint.

4 The complainants indicated that their daughter had been admitted to the Child and Adolescent Mental Health Service Inpatient Unit in December 2015 with low mood and suicidal thoughts. She had been referred to social work in late December 2015 and early January 2016 following allegations of historical abuse at home. A child protection case conference had been held in respect of both of their children following further allegations made in February 2016. At this time there was insufficient evidence to confirm significant risk of harm and the decision had been taken not to place the children's names on the child protection register.

5 The complainants indicated that during February and March 2016 their daughter had assaulted a nurse in an attempt to get into a medicine cabinet, violently attacked a nurse, breaking her arm and assaulted another resident and nurse.

6 The complainants advised that on 21 March 2016, the social work services had been advised that their daughter's clinician felt that she no longer met the criteria for the Young Person's Unit and would be discharged from their care within 48 hours. A place had been identified at a Young People's Centre but the complainants felt that the placement was not suitable to meet their daughter's needs.

7 The complainants indicated that their daughter had absconded from the Centre on the day after her arrival and had to be returned there by the police who had expressed concern at their daughter's mental state. The complainants felt that their daughter should have been placed in secure accommodation at this time and that not enough priority was being given to her mental health issues. Following two further episodes of running away from the Centre, during the second of which she placed herself in danger, she had been placed in secure accommodation for her own safety.

8 The complainants stressed that they felt that many of the reports into the health of their daughter were not balanced and that Social Work reports had contained inaccuracies. They further felt that the risk assessment carried out was neither sound nor robust and that the decision to place their daughter in a Young People's Centre was not rational.

9 Members of the Committee were then given the opportunity to ask questions of the complainant.

10 The Investigating Officer confirmed that the clinician at the secure unit had decided that the complainants' daughter no longer needed or met the criteria for secure accommodation and that a placement in the Young Person's Centre would be suitable. This had been based on the assessment of the child's needs with additional support being provided on an outpatient basis.

11 The Investigating Officer acknowledged that the move to the Young People's Centre had had a huge detrimental effect on the complainants' daughter but confirmed that the discharge from a medical facility was the responsibility of the clinician involved and that the social work services were unable to prevent this from happening. He indicated that managers within the service were confident that the Centre would be suitable with the correct outpatient input.

12 The Investigating Officer indicated that the Council were working towards agreeing discharge protocols with the NHS and that they would feed back to the family on the outcome of these discussions.

13 The Investigating Officer stressed that during the investigation into allegations of abuse, they were unwilling to access the complainants' daughter's phone messages as they were trying to build a relationship with the child and felt that this would be a breach of their trust.

14 The Investigating Officer believed that there was documented evidence that the complainants had been interviewed and listened to in regard to their daughter's situation and the investigation had found that the complainants had been kept informed at all stages. She stressed that the language used within the investigation was standard language and that she felt that the wording did not reflect badly on the parent but were presented objectively.

15 She stressed that factual inaccuracies had been altered but did not change the decision making process.

16 Members of the Committee were then given the opportunity to ask questions of the Investigating Officer.

17 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 3 (i) above.

   The Committee felt that the Council had completed a risk assessment and found appropriate accommodation with out-patient mental health support. When this NHS support failed to materialise, the Council had secured mental health nurse support.

   The Committee recommended that the NHS and Council Social Work Service review discharge and handover procedures to ensure that they were jointly agreed and completed with the safety of the child being paramount.

2) The Committee did **not uphold** the complaint set out in paragraph 3 (ii) above.

   The Committee felt that the accommodation provided was appropriate for the complainants' daughter's needs.

3) The Committee did **not uphold** the complaint set out in paragraph 3 (iii) above.

   The Committee's recommendation in decision 1) above, also applied in this case.

4) The Committee did **not uphold** the complaint set out in paragraph 3 (iv) above.

   The Committee felt that this was seen as a breach of practice and that the Social Workers involved were trying to develop a relationship with the complainant's daughter.

5) The Committee did **not uphold** the complaint set out in paragraph 3 (v) above.

   The Committee believed that there had been inaccuracies in the report which had been corrected. The inaccuracies had been minor and had not impacted on the decisions.

   The Committee recommended that reports be issued timeously to allow the family time to comment and make any changes.

6) The Committee **partially upheld** the complaint set out in paragraph 3 (vi) above.

   The Committee believed that a Social Work review would have taken place even if a complaint had not been received. However, communication from the Social Work Services on this had been confusing and misleading.

   The Committee also noted that the Department had agreed that the outcome of the inter-agency review would be communicated to the complainants and hopefully this would provide assurance that lessons had been learned.

Background reading/external references

Agenda, confidential papers and minute of the Complaints Review Committee of 1 March 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.	