



LOTHIAN REGIONAL COUNCIL  
**SOCIAL WORK**

# **Listen - Take Seriously What They Say**

A review of present and planned arrangements for responding to complaints from young people in care, with recommendations for further action

Prepared for John Chant, CBE  
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# I INTRODUCTION

## (A) THE REMIT

We were appointed at the end of August 1992 by John Chant, Director of Social Work, Lothian Region to prepare a report. The terms of the remit were as follows:

*"To review the recent changes already introduced to the Social Work Department's Complaints Procedure, and the further changes now proposed with a view to advising the Social Work Committee on the effectiveness of the arrangements for dealing with complaints from young people in care: this task to be undertaken in the context of comments made by Lord Caplan at the close of a trial which took place in the High Court in Edinburgh on 13-17 July 1992 involving a residential child care officer of the Social Work Department."*

This report looks at the children and the young people who are in the care of the Lothian Region Social Work Department and reside in residential units of some kind. We have not been asked to consider young people in foster care, although much of what we write about the handling of complaints would apply equally to them.

## (B) FEATURES OF THE CASE

Some of the salient features of the case which arose in the summer of 1992, were as follows:

A male employee of the Social Work Department who had worked for a number of years in different Residential Units was sentenced to a term of imprisonment after a number of offences committed by him against young female residents in care in these Units, were proved after trial at the High Court at Edinburgh. The offences had occurred during a period 1984 to 1991 and involved a number of girls, then aged approximately 13-16 years.

Of the complainants:

- a. Some had never told anyone of their experiences at the time while they were in care. What had happened to these young women only came to light when the Police made extensive enquiries of all residents in the relevant Units after matters were referred to the Police in 1991.
- b. At least one resident's complaint was interpreted by the Unit as a statement about her sensitivity to physical contact, and the matter was dealt with within the Unit and pursued no further at that time.
- c. Disciplinary proceedings were taken by the Department in 1985/1986 about one girl's complaint. These enquiries did not lead to disciplinary action being taken. There was no mechanism to search for and collate any other incidents

which might be recorded other than in central disciplinary files. The matter was not referred to the Police. The intention at the time to offer counselling to and monitor the practice of this member of staff was not carried through.

- d. A subsequent complaint by another resident in a different Unit was withdrawn by the complainer shortly after it was made. No examination of the reasons for the withdrawal appear to have been made and the incident was not collated with earlier incidents. Therefore no pattern of behaviour was perceived at the time.
- e. Finally in 1991 a complaint led to investigation by the Department and the Police. Criminal proceedings resulted in the member of staff's conviction not only in respect of the matter complained of at that time, but a number of the previous matters as well.

Preparation for attendance at The High Court and giving evidence in the trial was a source of anxiety for the witnesses who in the main comprised residents, former residents, residential staff and police. The original trial diet had to be postponed after the witnesses had received their citations. This postponement contributed to less than satisfactory support arrangements being made for the witnesses in Court. The trial lasted four days. On the first day only one member of staff not actually involved as a witness attended and his role in Court to observe proceedings for the Department meant he could not be with the witnesses. For the subsequent days additional staff attended with a specific support remit. They found the witnesses ill-prepared for what was expected of them, angry and stressed. The young people found the giving of evidence and the rigorous cross examination conducted by Counsel for the accused confusing and harrowing. Their anxiety was exacerbated by the freedom of the accused, who was on bail, to wander round the Court precincts during recesses and by the presence of a number of members of his family whose disapproval of them and their evidence was ill concealed. Part of that anger was directed at the Department for their failure to protect them from abuse.

Despite their initial anger the witnesses welcomed the presence of these additional staff members who comprised one person who was known to many of them and the Client Services and Complaints Officer. The young people took comfort from the Jury's verdict, not directly related to the result for the accused, but more from the fact that the decision meant that they had been believed. Most of them took advantage of a subsequent personal invitation from the Director to lunch and appreciated the opportunity that this provided to tell him how they felt about the whole matter.

All but one of the young people who did register complaints about what was happening to them made those complaints to female members of residential staff usually junior ones in status. Only one girl told her field social worker and, as far as we are aware, the young people concerned did not go to any other people or agencies.

During most of the period when this person was employed by the Social Work Department, all the managers of the units and the senior managers of the residential services for children, were male. Only on the last occasion were both male and female staff involved in taking action about the complaint.

The member of staff concerned had served in various capacities in three different Residential Units. His employment required him at times to be peripatetic between different Units. When he joined the residential child care service he had no relevant qualifications for the work. As far as we can see, he received no systematic training and may have had no training at all. His work was not supervised in any consistent way. In respect of the recruitment, training and supervision practices he was no different from many other members of staff working in residential units for children.

(C) METHOD OF APPROACH

From the outset the Director made it clear that his intention in establishing the enquiry and our remit was not designed to form a finger-pointing, blame-apportioning exercise. Rather he hoped that we would adopt a positive future approach designed to see how the Department could endeavour to ensure that children in residential care were not subjected again to the indignities of being victims of the type of offences established at the trial or indeed any violation of their rights to safety, privacy or denial of good standards of care.

While we required to examine the details of the trial, to learn from the actual experience, it was the stated future purpose of the remit which led to our willingness to participate. We should, however, acknowledge that while the majority of individuals we met during our work welcomed this approach, and we have no doubt that it contributed to their willingness to be open with us, we did detect in a number of areas that there were those who believed that the perceived failings of the individual members of the Department in regard to the matters which gave rise to the trial, merited a more specific examination of such faults or errors of judgement as may have taken place.

We would wish to acknowledge the enthusiastic, co-operation of all individuals who we asked to see, despite the considerable intrusions which we made into their thoughts, time and work. We asked for and were provided with masses of paperwork in regard varied issues such as – Complaints Procedures, Unit Records, Training Courses, Recruitment Procedure, Care Standards and literature – all of which we found very valuable.

It was our decision, supported by the Director, that whilst it would have been possible to carry out a remit based on the paperwork and the observations of a few key members of the Department, such an approach would be too narrow to allow any meaningful report to be produced. We therefore decided to meet with a large number of individual members of the Department, both Managers and practitioners, though many would, of course, claim to be both. At an early stage of our enquiry we realised that the 7 Service Provision managers now played a key role in regard to the Complaints Procedure under the new structure and we accordingly arranged to meet with, or speak with, all 7 of them.

It seemed important to try and obtain information from the Units themselves and in particular from young people who were resident therein. We accordingly visited 7 different Children's Units and welcomed the opportunity of speaking with staff of different levels of experience and with residents.

Although we have no doubt that we would have found it valuable to meet with the young people who had been identified as the victims of the offences in the High Court trial, we decided that we would not put any pressure on them towards having such a meeting in respect of the pressures which had already been placed upon them. We certainly would not have wished them to feel cut out of the enquiry and we accordingly wrote to each of them indicating that we would welcome the opportunity of meeting with them if they cared to do so and that they might be in a very good position to give us information which could assist others who were in care at the moment or who might be in care in the future. In the event only one of them, and she after waiting for some months to decide to respond, elected to see us. That meeting proved a very constructive one for our purpose and we would wish to acknowledge our appreciation to the person concerned and her courage in getting in touch with us.

We recognised that individuals in other Departments of the Regional Council might have information to contribute and we had meetings for this purpose. Again we would wish to acknowledge our appreciation of the constructive and co-operative approach taken by these individuals.

For some of our work we participated jointly in meetings. At other times and in particular out of a wish to speed up our enquiry, we allocated the work between us. We endeavoured to have a relatively set approach to our meeting with the staff and residents in the Units to try to present a consistent approach. During our work which extended over 5 months, we met regularly to discuss progress and to bring each other up-to-date with individual interviews which had been carried out.

Prior to the commencement of our enquiry the Staffordshire Child Care Enquiry of 1990, "The Pindown Experience", had been published. During the course of our work the Warner Report and Skinner Report "Another Kind of Home" which dealt directly with issues which we were considering, were published. We endeavoured to take on board the reading and recommendations of these reports in considering our work.

As we were on the point of finalising this report a further Report which deals directly with the issues in Leicestershire involving Frank Beck was published and received wide publicity.

A list of those individuals whom we saw is produced at APPENDIX A.

We considered whether to include a summary of the report. In light of its length, the numerous elements we have considered as outlined in the List of Contents, and the summary of recommendations which are listed separately, we concluded that a summary of the whole report was not required.

#### (D) THE UNCHANGING CONTEXT

There is very extensive literature now about child abuse, and about the management of residential care and other topics relevant to the areas under consideration. Because there is so much work being done, and so much



information available, and because there have been so many changes and developments, there is perhaps a danger of not recognising and taking account of the essential underlying dilemmas and factors.

We suggest that some of the key dilemmas are:

- a. **Dilemmas occurring in all cases of child abuse.** These dilemmas are well-known. Much abuse, particularly sexual abuse is a secretive activity. Credibility quickly becomes an issue, particularly where there is an absence of medical evidence to corroborate the story which the young person is telling, adults may find it difficult to believe the young person and problems arise about validating the story. It is known that victims frequently retract the story which they tell, particularly when the allegation is one of sexual abuse.
- b. **Special dilemmas arising for children in care.** The power in any residential situation rests in the hands of the staff and not the residents in nearly all cases. It is important to realise that scandals occur not only in children's residential units but in other settings where there is a similar imbalance of power, for example, hospitals especially long-stay mental illness and mental handicap hospitals, prisons, residential schools of all kinds, residences for elderly people and in other total living situations such as that experienced by recruits to the armed forces. There is extensive literature about institutions and the problems of their management.
- c. **The dilemma of the Social Work Department investigating itself.** The Social Work Department normally plays a lead role in investigating cases of child abuse. Where an allegation of abuse by a member of staff is made by a child in a residential unit, the Department faces additional dilemmas and difficulties. The extra dimension of requiring to investigate as a disciplinary authority the possible perpetrator, can lead to a lack of focus on the paramount need to protect the child and consider the child's welfare. There are extra pressures against thorough and impartial investigation of a case of child abuse within the investigating authority's own staff group and a particular need for external agencies to be involved in these enquiries.

## **(E) CHANGES SINCE THE CASE**

This section notes, without comment, the various changes which have occurred since 1984 and which appear to us to be significant. The details of the changes, how significant they may be and whether further changes are required are discussed later in the report.

### **(1) LEGISLATIVE CHANGES**

There has been a number of legislative changes which affect this area of the work of the Social Work Department. These include the legislation requiring the setting up of arm's length registration and inspection units. These units are now in existence and inspection of the Authority's own residential units for children is about to begin in Lothian.

The law now also requires the setting up of Complaints Procedures and the appointment of an officer to deal with complaints. We noted that Lothian introduced their procedure and appointed staff for these purposes prior to their being required to do so by legislation.

The United Kingdom is now a signatory to the United Nations Convention on the Rights of the Child which in addition to general issues of rights for all children has specific relevance for children in care.

(II) **CHANGES IN ARRANGEMENTS WITHIN LOTHIAN AND WITHIN LOTHIAN REGION SOCIAL WORK DEPARTMENT**

**Staff Discipline Procedures:** The Discipline Procedures for staff in Lothian Region are laid down at a Regional level not Department by Department. The discipline procedures have been reviewed on more than one occasion since 1984. The current discipline procedures date from December 1991.

**The Review of Residential Care:** This Review has been underway for some time. An initial report identifying a number of deficiencies in the provision of residential care for children was produced in a climate of national recognition that residential care for children was under-resourced and inadequate. A comprehensive Review report was then presented to the Social Work Committee and new structures within Residential Units have been put in place. We will not attempt to summarise these extensive documents here but refer to them for their terms. In particular we would highlight the new management structure within Units, more staff paid at a more adequate rate and a considerable commitment to training. As part of the development of residential care and the work of the registration and inspection unit we note the terms of the extensive "Standards: Residential Child Care" document. A training programme involving staff attending courses provided externally and on an in-house basis has been put in place.

**Departmental Re-organisation:** The Social Work Department has undergone extensive re-organisation. The previous Residential and Day Care section of the Department is now no more, and management of services devolved, in large measure, to the 7 Districts. We note the intention of the new structure to integrate residential and fieldwork services within Districts. The implementation of the re-organisation programme was ongoing at the time of this report. The Districts "took over" in early October 1992, and most of the residential units were in process of settling in to new staff groupings and the new regime as we were undertaking this work. The changes were less significant so far as the centrally-managed schools, Wellington and St Joseph's, and Howdenhall and Comiston Units were concerned.

**Complaints Procedure:** The Complaints Procedure for all clients has been operational for some time and the Client Services and Complaints Officer has been in post for more than a year. Within Lothian the Client Services and Complaints Officer is not located in registration and inspection, as in many other Authorities, but reports directly to the Senior Depute Director and the Director.

**"Who Cares?":** The organisation for children in care in Scotland has now appointed a Development Officer for Lothians and Borders who arrived in post in November 1992 during the preparation of this report. We had an opportunity of meeting with the postholder. The Region is providing financial and logistical support to this post, but the postholder is not a member of the departmental staff.

**"Children's Rights Officer":** There is a proposal to appoint a "Children's Rights Officer" to Lothian Region Social Work Department.

**Lothian Region Family Charter:** Lothian Region has put in place a Family Charter, the arrangements for which include the appointment of an adjudicator to deal with matters of unresolved complaints. It is noted that the Charter applies both to the Social Work Department and other services provided by the Region including Education

(F) THE YOUNG PEOPLE WITH WHOM THIS REPORT IS CONCERNED

There are a number of different groups of children in the care of Lothian Region who are placed in residential facilities. There are children in residential units run by Lothian Region, these include two schools, Wellington and St Joseph's, the central units at Howdenhall and Comiston and Young People's Centres in the Districts. Children are also placed by Lothian Region in facilities run by others. Some are located within Lothian Region and therefore subject to registration and inspection by Lothian Region. Others are located outwith the Region and managed either by other Local Authorities or other bodies which are registered with and inspected by the equivalent service of their Region. Currently there is at least one child placed outside Scotland, which is by no means an exceptional circumstance. Further details of the children in residential care at the end of 1992 are contained in APPENDIX B.

We have found it difficult to define exactly the group of children in residential care who have access to the Complaints Procedure of Lothian Region Social Work Department. There are, for example, children in various settings for whom responsibility is shared between social work and education departments, and some children who are in health facilities but also receive social work care. A further complication arises when a child is the subject of a Supervision Requirement to a Children's Hearing which the Social Work Department is responsible for carrying out. For example, does a child who happens to be

subject to such a requirement and is placed in a hospital unit as part of that requirement have different access to the Social Work Department Complaints Procedure from a child in the same unit who is not in care or subject to a Supervision Requirement?

**(G) SOCIAL CONTEXT**

**(I) SEXUALITY, SEXUAL HARASSMENT AND GENDER ISSUES**

It seems widely recognised that in Scotland we have a culture of inappropriate male sexual exploitation of women. That sexual exploitation, including that of junior employees and members of staff, such as conversation shot through with sexual innuendo, but also including physical intrusion such as "playful" smacks on female anatomy, is still viewed by some males as innocent fun; with an implication that those, including the recipients of such behaviour, who make a fuss over such matters, are themselves somehow inadequate.

Legislation and case law regarding sexual harassment is making considerable inroads into curbing such behaviour. Senior management in the Social Work Department are fully aware of the changes. These matters are written about extensively in social work and "normal" publications. Nonetheless it will take some considerable time for the undesirability of such practices to be so widely accepted that the problem is eradicated. It may not be without significance that the staffing and in particular the senior staff of those units where the offences in the High Court trial took place was a predominantly male one. Such staffing might make it easier for a male member of staff to carry out the course of conduct complained of – that other male colleagues may fail to recognise what was sexual intrusion and may interpret this as "harmless fun" or "banter".

So far as we could ascertain from our visits to Units, efforts appear to have been made to find a gender balance in the appointment of staff, in particular to promoted posts. We commend such a policy and share the Director's belief that such a policy constitutes a positive contribution to addressing the issue. We have commented in the section on training on the central importance of training on questions of sexuality, attitudes to physical care, boundaries of proper conduct within the unit. As we have indicated it is not enough for senior management to recognise the issues. It is essential that all staff be helped to recognise the problem and take on board the implications.

**(II) KNOWLEDGE OF ABUSE INCLUDING ABUSE IN CARE**

Practitioners at every level from Director to temporary unqualified worker must now be well aware that very many children are the victims of abuse and inappropriate behaviour. The media remind us of this daily; they make it clear that abuse is not restricted to children living in their own homes and that the actual incidence of sexual interference with children in care is much higher than was ever previously imagined.

Social work practitioners might have been tempted to believe that such incidents were restricted to Ireland because they had read about Kincora. When we spoke to staff they knew all about Pindown and about Frank Beck and all that prior to the publication of the Warner report. In particular Lothian Social Workers know about the incidents which gave rise to our remit and from the publicity that attended that trial and other trials, they are much more alert to the possibility of such behaviour.

That greater awareness must help all staff to be conscious of their responsibilities in regard to protection of children in whose care they share. It must help senior staff to be alert to the possibility that junior and other staff might be involved in such conduct in the future.

**RECOMMENDATION I** We recommend that the current impetus provided by the Warner Report and the Lothian High Court trial should not be lost and that direct reference to such matters in future training would help to make the issue a relevant live one rather than a theoretical possibility.

## REVIEW AND DISCUSSION

### (A) ATTITUDES AND PRACTICE WITHIN THE SOCIAL WORK DEPARTMENT

#### (1) ATTITUDE OF MANAGEMENT

We would wish to acknowledge initially the very clear lead and message which is being given by the Director and by senior management about the issue of hearing children and acting on what they say. In one way this message has been reinforced by the instruction of this report and by its having been made abundantly clear that we had a totally free hand in our enquiries, encouragement that these enquiries should be extensive and by it having been made clear to staff at all levels that co-operation with the report constituted a priority.

The paperwork emanating from Shrubhill puts a priority on the Complaints Procedure and the standards of care to which young people in residential units are entitled. Staff know that when a young person has a complaint the Director wishes to know about it personally. Nor is this just a paper exercise. Young people know that if they were concerned about any matter they can write to the Director. Invariably they know his name. On our visits, young people to whom a hypothetical situation was presented responded that in that situation they would "write to John Chant". When pressed how they would go about doing that one indicated that she would adopt the same course as she did the time before. She gave an account of how she had written to the Director and he had come to the Unit, had tea there and discussed the incident at issue with her. Throughout our visits all staff seemed very clear about the Director's keen personal interest in this area of work and that young people in their care were equally well aware of it.

Such an approach does not receive unanimous unqualified approval. Some veiled hints were made to us that the personal interest of the Director and senior staff rendered issues of responsibility and management difficult. Suggestions were made that this approach meant that the Director could be needlessly and inappropriately involved in matters which would be better addressed by a line management approach and that too early involvement of the Director could lead to the responsible staff losing credibility.

Another somewhat muffled area of anxiety for staff related to the power that was now vested in children; that the willingness of the Directorate to listen now to children (lying? exaggerating? malicious?) rather than the staff (trusted? experienced? objective?) constituted an unfortunate balance in this field. It is proper however to acknowledge that there were very many clear statements of welcome for the lead from the Directorate.

Those who are concerned about the issue of line management do not restrict this area of concern to the Director himself. They worry that this approach might be mirrored by several senior members of the Department including the Senior Depute, Depute Director (Operations), Unit Manager and Service Provision Managers. We recognise that such issues may create occasional individual problems for middle managers but our admittedly safe vantage point of outside observers, with no practice responsibilities, we commend the Directorate lead and approach. Indeed we would support the concept that senior members of the Department do visit the Units when they are able to do so, not so much in relation to individual issues – though we would have confidence that they would have the sensitivity not to undermine staff in the way they addressed individual matters. We were not a little surprised to find how interested many of the young people were in our own visits and would wish to acknowledge how courteously they received us. Visits by Managers could, we suggest, be even more welcome; they would continue to deliver the message that the Department is interested in the young people as individuals and reinforce the message that if these young residents have areas of concern, that avenues of communication are open to them. Complaints apart, contact of this sort would provide for Managers an understanding of the atmosphere which obtained in a way which cannot be reproduced by paper or oral reports.

We have already referred to the key role of Service Provision Managers. In some of the Units we visited the identity of these individuals and their responsibilities were well known to the young people. We would hope that those managers who visited Units in regard to their staff responsibilities would make a point of meeting with the residents and being known to them. Throughout our visits and in this report we recognise that many young people would only be able to communicate complaints to individuals who are personally known to them and that these are the only individuals that they can trust. We would be anxious that Managers who visit Units and speak only to staff might be perceived by young people who were concerned about the way in which they were treated as being too close to the staff to offer any potential source of help to residents.

- (II) **ATTITUDE OF STAFF WHO BECOME AWARE OF MISCONDUCT**  
We recognise that inappropriate staff loyalty can be a barrier to recognition and action. The social work profession is in no way unique in this regard. Some of the staff to whom we posed hypothetical questions about physical ill-treatment of a particularly troublesome child by a hard-pressed colleague as to how they would deal with such actions by colleagues or complaints by residents, accepted that it might be very difficult to take the appropriate action. Not surprisingly, in the light of our remit, they were able to convince themselves that if it came to the bit they would do so. In our, very limited, sample we found it interesting that the more junior

the member of staff the more straightforward the issue seemed to be, possibly because these staff had not been members of a staff unit for so long and formed the same strength of relationships and loyalties. Even more interesting was the observation that in the current climate of opinion staff recognised that failure to act would in itself constitute a breach of their obligations and, laying aside the morality of the issue, self-interest dictated action being taken.

That last matter may be one of particular and general relevance to indicate that "things are different now". In our enquiries about the trial incidents a clear view was expressed to us from two sources that the examination of these matters had been adversely affected, not so much by misplaced loyalty to a fellow staff member, but a sense of personal guilt relating to a failure to recognise and deal with early indications of inappropriate behaviour.

We are not suggesting that staff set out to police the acting of their colleagues to detect aberrant behaviour by them. Quite apart from anything else if one sets out to look for something one is likely to find it whether it is there or not. Rather the proposal is that staff should be alert to the possibility and in the light of their knowledge that such behaviour is possible and has occurred in the past, take steps to share any concerns in regard to this area with the most appropriate colleagues. Certainly this awareness ought to ensure that when a young person makes a complaint, even if it is subsequently withdrawn, or it is made in a less than direct fashion, that that member of staff does not brush the suggestion aside.

In considering the issue of withdrawal of complaints we, and hopefully staff working in units, recognise that young people might have a variety of pressures, including ambivalent attitudes towards a perpetrator, peer group pressure and reluctance to be involved in an enquiry, to withdraw a complaint, which was in fact true. It appears to us that these pressures operated in the case which had gave rise to our remit.

- (III) **HEARING CHILDREN AND TAKING WHAT THEY SAY SERIOUSLY**  
Given that there is now a much greater awareness of the prevalence of inappropriate behaviour, young people who do make such complaints are now much more likely to be believed than was previously the case. Lord Butler-Sloss and Lord Clyde warn us about the dangers of believing everything children say but also require that we take seriously what they do say. In that climate, it is to be hoped that where children, as happened in the case giving rise to our remit, make allegations, they now would not be brushed aside. Workers to whom such allegations were made, or who were advised of such allegations, might be expected to take what was said seriously and investigate the matter thoroughly.

Not surprisingly we did have some reservations expressed to us that a number of children in care have proved in the past to lie in relation to many important issues. Concerns were expressed that such young people, well aware of the current climate in relation to complaints, were being provided with an opportunity of power which a number of them



might be ready to exploit. Staff in exercising their responsibilities to carry out appropriate control might be victimised by residents. In this connection we were concerned to learn that some staff had interpreted these matters as requiring need for duplication of staff wherever a child goes lest the lack of corroboration might put a member of staff's career and reputation at risk.

These observations of power for young people contrasts starkly with the feeling of powerlessness that the young people who gave evidence experienced. Counsel for the accused in the trial was not slow to attack the credibility and reliability of the witnesses, based on previous dishonesty and acting-out behaviour. We had in fact been led to believe that despite the conviction of the accused that there were many members of the Department who were anything but convinced of his guilt and that those who harboured such doubts were concerned that the "lying" witnesses had perpetrated a miscarriage of justice. We have to say in this regard that we met a number of staff who had worked with the accused, some of whom had required to give evidence in the High Court trial, and not one made any such suggestion to us and indeed expressed surprise that such suggestions were being made.

This new awareness will not lead by itself to incidents being dealt with effectively where the young person for whatever reason feels unable to make a complaint or allegation. In this regard we were interested to learn from the one witness who spoke to us that, whereas she had made no direct complaint "because she would have been too embarrassed to do so" she had taken the chance with other residents to refer to her concerns in an informal situation with a young residential care worker. According to her recollection the group of three covered their embarrassment by laughing and joking about the sexual matters and making less than direct references to the man who was subsequently convicted of the offences in that regard. She felt that this had been an attempt to raise the issue but her recollection was that the care staff member joined in the joking and that ended the matter. She did not of course know whether the care worker had picked up any of the nuances and shared it with colleagues but she suspected that this had not happened. Certainly nobody had approached her and as far as she knew her co-residents about what had been said.

It is to be hoped that greater awareness, coupled with appropriate training would enable staff, including fieldwork staff, to pick up on unarticulated concerns whether by oblique references or manifestations of unexplained behaviour. It is also to be hoped that in addition to staff ready to "hear" and "listen to" concerns that the provision of additional potential avenues of communication will enable young people who might otherwise be unable to articulate their worries to do so. Reference is made to the sections on the Client Services and Complaints Officer, Children's Rights Officer and Who Cares Development Officer.

(B) RECRUITMENT

(1) THE PAST

As recognised in the Skinner Report and other reports emanating from the south of the border, Lothian is not alone amongst Local Authorities who employ a predominantly unqualified staff in residential care, including care for children.

Recruitment to posts of Residential Care Officers in Lothian had in the past been haphazard. While the phrase which we heard repeatedly in the course of our enquiries "brought in off the street" may not accurately reflect the way in which staff were recruited, it was certainly the position at one time that very little enquiry took place before some members of staff were permitted to work in this area. Officers-in-Charge of Residential Units were frequently expected to find staff for themselves in emergencies and were encouraged to bring in people who might be able to help out. Many of them then stayed on in post. Managers in using their local knowledge, frequently selected committed people who helped provide appropriately for young people's needs. At other times those who were called in proved to be less satisfactory but though it might have been difficult to find appropriate staff it seemed to be equally difficult to dispense with the services of those who proved to be less than satisfactory. No policy existed in relation to employment of spouses, other relatives or friends.

It is a matter of record that the member of staff who was involved in the High Court trial had been employed in the Department for a very long time as a Temporary Residential Care Officer. He was classed as a "Peripatetic" although it appears that he may have graduated to a permanent position. He frequently filled in for vacancies in Children's Homes normally in his own territorial Division. On occasions he, as was the position with other temporary staff, worked in emergencies on a cover basis for other territorial Divisions.

Extensive use was made by the previous Residential and Day Care Section of temporary appointments. The Regional Council Policy is against the concept of probationary appointments except for "young" employees by which the Region means those under 18 years of age. It is hardly to be envisaged that persons under 18 will be employed as Residential Care Officers.

To an extent Lothian might argue that temporary contracts were used to act as probation in respect that new applicants to the field of residential care tended to be appointed to temporary posts in the first instance. Whereas the origin of temporary appointments might have been that of uncertainty about budget or staffing levels the fact remains that the temporary nature of the contract gave the opportunity to discontinue such employment if the person showed that he or she was unfitted for the task. It must however be acknowledged that as it operated and indeed appears to operate, failure to continue a temporary contract would be construed as a failure of the staff member yet there is

no explicit expectation that a member of staff would receive supervision and support or any assessment on a formal basis as to how they were progressing in their work. It has been suggested that extension of contracts reflects, in many instances, expediency and avoiding unpleasantness rather than constituting any acknowledgement of the member of staff's ability.

(II) **AN IMPROVED TEMPORARY POOL**

Prior to the disbandment of the Residential and Day Care Section, through the initiative of individual Assistant Principal Officers, attempts were made to address some of these deficiencies. Applications were required; interviews were held; police checks were made; references were taken up. A pool of people deemed to be capable of the work was formed on a Departmental basis – it was significant that a substantial number of applicants were rejected by the process. Units who were short-staffed could then obtain approved personnel from the pool. Through appointment of these people to posts the pool came close to running dry.

(III) **CURRENT POSITION**

The function of recruitment of staff has now been removed from the former Residential and Day Care Section and constitutes a District responsibility. Police checks are now automatically carried out with the assistance of the Personnel Section and a reference from a previous employer is insisted upon. It is understood that these requirements relate to both permanent and temporary appointments. Interviews take place, usually conducted by the Service Provision Manager and Unit Manager. Dependent on the seniority of the post the District Manager may be involved. Arising from the recent staff reorganisation, a large number of permanent appointments have been made. Service Provision Managers had indicated to us their preference, wherever possible, to have permanent appointments made.

Nonetheless, for various reasons, needs arise for temporary staff. Under the new District structure, attempts were made to ensure that individual Districts would interview people locally with a view to each District having its own pool, yet having the flexibility of lending to, and borrowing from, other Districts when the need arose. So far as we could gather there may currently be difficulty in ensuring that there always will be approved staff available for emergencies. We are advised that Managers have the right to appoint temporary Residential Care Officers for a maximum of 7 days. (Director's Circular No.12, July 1992).

(IV) **PROBLEMS ARISING FROM DELEGATION TO DISTRICT LEVEL**

While the new structure of the Department is geared to encourage self-sufficiency at District level, there may be merit in a Regional approach to the issue of recruitment of staff.

Each District ought to be providing the same high standard of recruits to work in this field. It is hard to visualise seven Districts, each charged with individual responsibility for recruitment establishing a consistent, across the Region standard. It is recognised that there are dangers in seeking to go back to what might be seen to be a Residential and Day Care Section by another name but, in any event, the centralised Personnel Section of Headquarters are currently involved, and likely to remain involved, in recruitment. We would suggest that it would be difficult for the seven Districts each to have personnel expertise of the order necessary to deal with this sensitive and critical area of staff recruitment.

One of the ways in which personnel are currently involved is that of police checks. The frequency with which respondents told us about the requirement for police checks gave us some concern that the fact that applicants might pass that test, could be seen to be something in their favour. In fact police checks show very little – they would not for instance show, or be allowed to show, allegations about a person which may not have reached the high standard of proof beyond reasonable doubt of a relevant offence in respect of a child albeit that there may have been sufficient information on the balance of probabilities to show that the person was likely to have been responsible for such an offence. An initial police check on Frank Beck would have disclosed no information to show his unfitness for a post as Child Care Officer.

Centralisation of the function of recruitment could enable a consistent approach to be taken to the issue of references. It is well known that references are not necessarily a good gauge of suitability. Their potential inadequacy notwithstanding they are of limited value and it might be appropriate in a centralised function to increase the number sought from one to a minimum of two to include that of the last employer and any reference from any social work agency with whom the applicant has been employed or involved.

Just as references are not always a good guide so it is recognised that interviews by themselves are not necessarily the best guide to informed and valid decision making. Again however it is suggested that placing the area of work within the centralised remit would encourage a consistent approach to be adopted. Those who sat on interview boards would hopefully all have had the experience of the Regional Training in Recruitment before being allowed to participate in the interviews. A relevant interviewing board might comprise one personnel individual together with two practitioners, professionally involved in social work who could participate on a rolling basis from the various Districts.

**RECOMMENDATION 2** We recommend that the Department consider the need for consistency and thoroughness in selection procedures for staff in residential work for children, and in the light of that requirement develop methods of recruitment. It may be that such requirements can best be met by a combination of expertise from central and district staff. At the very least centralised personnel section and managers should oversee closely the recruitment policy and process to endeavour to ensure these standards of consistency and thoroughness.

(v) THE FUTURE

It was our understanding from our meetings with staff currently involved in selection that many of them are adopting the practice of including issues such as care and control in the interview process to help the interviewers assess candidates' suitability. We commend these plans which additionally give those who are being interviewed some understanding of the expectations of the Department in sensitive areas of work and ensure they have a firm understanding of these requirements before they actually commence work.

**RECOMMENDATION 3** We recommend that the Department continue and extend the practice of including in interviews issues such as care and control, sexuality and complaints from children.

The future recruitment of staff to the demanding task of child care would be enhanced by an emphasis being given to permanent as opposed to temporary appointments. To attract persons of the right calibre it is essential for them to have the security provided by a permanent appointment. We commend the views of those Service Provision Managers who are adopting this position.

**RECOMMENDATION 4** We recommend that efforts should be made to increase the numbers of permanent as opposed to temporary staff.

Coupled with the need for security for staff, we readily accept the clear recommendations made by the Warner and Skinner reports relating to the value of probationary periods.

The Warner Report (recommendation 35) recommends that "probationary periods of 12 months become standard practice for all new appointments to Children's Homes irrespective of whether a person comes from within the same employing authority or another Local Authority". Skinner (Recommendation 46) states "the Scottish Office should consider the applicability in Scotland of the recommendations of the Warner enquiry into the selection and recruitment of staff in Children's Homes and issue appropriate

guidance in due course" and specifically in Recommendation 51 stated "New staff with no previous experience of residential child care should be appointed on a probationary basis. Their appointment should be confirmed after 1 year only when assessed as competent."

The clarity of the recommendations of these two prestigious reports is such as to make it appear to us unnecessary to repeat the arguments at length here.

**RECOMMENDATION 5** We therefore recommend that despite the current Regional Council Policy, the Department attempt to establish a probationary period for residential staff.

Until such time as a probationary period can be established in conjunction with permanent appointments, we can see benefit in the use of temporary appointments incorporating authority to continue the contract for a maximum period of 2 years coupled with a stated requirement for continuous assessment during the period of the contract.

Such requirements could have considerable benefits for members of staff themselves. These benefits would include clarity of expectation, promotion of professional competence and self esteem and the formation of a real evaluation of the employees' suitability for the work. It would ensure that staff members had appropriate supervision and would benefit senior staff by providing a practice focus for supervision. It should certainly benefit the residents.

There would require to be an expectation that members of staff who successfully completed the contractual period and demonstrated their fitness for the task, should be provided with permanent appointments. There would be a further expectation that those who were not able to meet the high standards required in the area of child care, would not have their contracts continued.

The Assistant Director (Human Resources) has indicated that the Department, as a reflection of how seriously they are considering the importance of selecting the correct persons for posts in residential care, have in mind to establish psychometric evaluation prior to appointment. We are not qualified to know how accurate such assessment might be, and the practicality and financial availability of funds for this purpose. We recognise however that such thoughts give a clear indication of how seriously the Department is considering the issue of recruitment.

(VI) **A POSSIBLE DEVELOPMENT**

Whilst our remit is to examine the current Procedures as to their adequacy we would respectfully suggest that the Department gives serious consideration to establishing on a regular, say annual, basis a recruitment programme to form a cadre of Residential Care Officers and to include as part of that recruitment programme, the basis of

induction training. We appreciate that in all probability such a programme would have to be held in the evenings to allow those who were already in employment, but seeking a change of employment, to make application. We further appreciate that such a proposal would place a burden on already hard-pressed staff. In addition to anti-social hours for staff it might be necessary to consider payment of trainees for their attendance at the selection/training programme. A programme of this nature would allow a report to be prepared at the conclusion which would be of assistance to any interviewing panel in helping them to decide whether or not to appoint individual applicants. The programme could have the additional method of helping to screen out unsatisfactory applicants, possibly by self-selection. An approach of this nature could do much to raise the standing of the post and the self-image of those selected, albeit only in the first instance to the approved pool of potential employees. The model we propose is, we understand, analogous to present methods of recruiting foster parents.

**RECOMMENDATION 6** We recommend that in light of the foregoing paragraphs the Department consider creating an innovative extended recruitment programme incorporating training and assessment for residential workers with children.

(C) SUPERVISION

At the time of the incidents which gave rise to the trial there appeared to be no clear departmental policy relating to supervision of staff within residential units. Unqualified, untrained staff including those on temporary contracts were expected just to carry out duties of caring for residents with the proviso that there was an expectation in most units that they would seek advice from senior members of staff and that the latter would carry out "on the job" supervision by taking charge, advising and counselling as and when situations arose. There was no expectation that staff would have goals or targets to meet; there was no evaluation of what particular skills individual staff members lacked or how these could be built upon by training. As mentioned elsewhere there was little planned training for qualified or unqualified personnel.

We learned that the Department was now committed to a policy of supervision for residential staff and that this concept was recognised in the Job Descriptions for Unit and Assistant Unit Managers. In our visits to Units we found that some promoted staff were already putting such a policy into practice; that they were keen to develop these concepts and that the staff for whom they had responsibilities were equally enthusiastically disposed towards this practice and recognised the benefits that they themselves could gain.

In other areas, not confined to the Units themselves, we found what could be at worst resistance and at best indifference, to the concept. It was suggested that the tried and tested way of working alongside staff, observing their work and counselling as things happened from practical experience was the most effective

way of supervision and much to be preferred to the idea of sitting down in an "artificial" supervision session. It was suggested that such sessions would produce little except an opportunity to chat and that the sessions would lack relevance and direction. We recognise that shift rosters present difficulties. In considering the practicalities there was no agreement by current staff members that the new provisions relating to staff of residential units actually "freed" Unit Managers and Assistant Unit Managers to "manage". Absences arising from holidays, illness and freeing staff for training meant that senior staff would still be rostered for duty and staffing levels were not such as to allow time for set supervision sessions.

Yet another reservation was to the effect that the current emphasis ought to be on training rather than supervision; that in the area of fieldwork, supervision was being used for well-paid professionals to have an excuse to avoid their own professional responsibilities and seek refuge in a consensual approach for which the individual concerned carried less than appropriate responsibility.

We would strongly support the positive approach being taken by the Department to supervision in the residential sector. We recognise that despite the enthusiasm of some staff to embrace the concepts of supervision, there may currently be a lack of direction as to how this can best be achieved on a consistent regional basis. For a consistent approach these senior staff must themselves be provided with training as to how best to meet the objectives of supervision. Such training ought to recognise the role of the Service Provision Manager in supervising Unit Managers, the Unit Manager for supervising Assistant Unit Managers and for Assistant Unit Managers to supervise basic grade staff.

We would see the use of supervision as complementary to, rather than as an alternative to training. The supervision would be geared to aims and objectives that staff would be expected to meet to enable them to discharge effectively their duties of care for residents. Achievements and progress should be recognised and recorded. Gaps in abilities and expertise ought similarly to be identified and recorded. Consideration should be given as to how these gaps might be filled by taking advantage of relevant training programmes encouraging the development of appropriate programmes where none exist.

We would hope that the Service Provision Managers amongst their multifarious responsibilities would be able to ensure the provision of relevant supervision programmes for all staff in residential units. It does appear to us that there have already been meaningful changes to the concept of supervision since the time of the incidents which gave rise to the High Court trial; that there is now opportunity to build on that experience and that the new structure of the Department should assist towards supervision becoming a reality rather than just a concept.

It is a fact that the member of staff who was convicted of the offence in the High Court was not supervised in any consistent, recorded way. When disciplinary proceedings had been embarked upon, which turned out to be inconclusive, agreement was reached between the member of staff and management that he would benefit from supervision and support in the future. Even then, it appears that this decision and its implications were not communicated to the senior staff in



the Units in which that member of staff subsequently worked. It is readily recognised that there can be no certainty that supervision at any time would have ensured that the offences were not committed in respect of the children. Supervision of individual staff members' work however, could alert supervisors to potential areas of concern; confidence between supervisor and supervisee might well enable sensitive and potentially embarrassing topics to be discussed; many other areas of concern other than the traumatic ones of sexual exploitation, including "heavy-handedness" or "physical roughness" with residents and the use of sarcastic or insensitive communication could be addressed in a positive productive way.

In the light of the clear recommendations of the Warner (42-44) and Skinner (56) Reports and the supporting commentary in relation to supervision, when we have recognised that the Department is committed to the development of this issue, it could be suggested that there was no need for us to have written at such length. We have elected to do so in the light of what we have perceived to be a less than complete acceptance within units and management of the value of or need for supervision.

**RECOMMENDATION 7** We recommend the establishment of a consistent Regional, District and Unit policy for supervision, and that Service Provision Managers, in conjunction with their managers and the Training Section establish a training programme for those who will have the responsibility of supervising. Further, we recommend that the Regional Policy on supervision be developed and implemented on a shared basis drawing on the experience of good and bad practice.

## (D) TRAINING

### (I) INTRODUCTION

Previously there have been various programmes in place to provide training for residential staff but, we understand, these have been, on the whole, somewhat limited and ad hoc. The CSS course was a route to qualification which was taken by some members of residential staff but then sometimes became a route out of residential work and the proportion of formally qualified staff has not risen much over the years.

We have now noted the plans made by the Department for a five-year rolling programme leading to Diploma qualifications for Unit Managers, HNC or equivalent qualifications for Assistant Unit Managers, and appropriate in-house training as a minimum for all Residential Care Officers. This is clearly an impressive investment of resources in residential care training and a considerable improvement in terms of consistency and inclusiveness on what went before. We note too, the intention that significant numbers of residential staff will pursue studies at Dundee University for the Certificate in Child Protection. We

note the proposals in the Warner Report (Chapter 7) for a new 2-year Diploma course specifically linked to the residential child care task.

(II) **PHYSICAL CONTACT WITH CHILDREN**

Most allegations of abuse involve physical contact between an adult and a young person. This is the area where the most serious complaints about staff behaviour towards young people arise.

We therefore discussed the area of physical contact with the residents with young people and staff as we made our visits in the Department, and we have also looked at documents with a view to ascertaining where these matters are discussed and carried forward.

Specific enquiries about physical contact with young people were often interpreted as questions about disciplinary contact bearing on the question of restraint and control of children. This is clearly an anxious issue for staff and we note it to be the subject of considerable attention in the training programme for residential staff. Many staff were able to give us a clear account of their understanding of issues such as restraint, many had read the Care and Control document for example and had an understanding of the principles which informed the Department's policy in this matter.

Physical contact with young people, however, does arise in a number of other situations and we find it difficult to believe that disciplinary matters are actually the most frequent area where contact occurs. There is a whole range of behaviours to do with re-assurance, affection, ordinary everyday interchange in a domestic situation, as well as considerable areas around sexuality which require consideration. Most Young People's Units have residents who are nearly all in adolescent years where sexual matters are an insistent and essential part of their own lives. Residential staff need a full understanding of these matters and require to develop skills and a conscious, critical attitude to society and its values.

We found many staff much less able to articulate their views about these matters than they were about disciplinary matters. Some showed unfamiliarity as if these areas were not often discussed or had not presented themselves before. There was some embarrassment. There was much reliance on common sense practices from experience, particularly family experiences and reliance on sound homespun philosophy. We noted, with interest, that qualified staff often reflected to us that the most useful piece of their training in day-to-day work was the understanding they had of child development; as one person put it to us, "common sense is not enough when dealing with dis-integrated and damaged children".

Issues of physical contact are of course particularly acute for children who have already suffered physical and/or sexual abuse in their own lives before coming into care. It has become much more recognised over the last ten years that the population of children in residential care includes a very large number who are dealing with difficulties of this kind. The

Warner Report suggests (paragraph 2.28) that one-third is a low estimate. Most staff we sense, although not all, have an understanding that abused children may have very different experiences of touch and affection being shown to them. There appeared to be broadly two schools of thought among staff about how such children should be managed in residential units. The first took the view that children should not be differentiated from others and all should be treated in the same way to avoid further stigmatising the abused child and lowering the child's self-esteem. The second view held that physical contact with known abused children should be avoided on the whole because the young person might find such contact threatening or might misinterpret it. One or two also suggested that proper use of physical contact in care could in some ways be therapeutic and repair the young person's damaged perception of physical affection.

(III) CHILD PROTECTION

Within the present written in-house Residential Care Officer programme which we have seen, there appears to be little emphasis on aspects of care such as sexuality, affection or physical relationships other than disciplinary ones between staff and young people. With the exception of some senior staff who have attended the Dundee University Certificate in Child Protection Course, few of the staff in residential work appear to have had any specific training about child protection, any experience of working with the Guidelines, or much understanding about the whole topic of abuse, far less a specific understanding of sexual abuse perpetrated by abusers who specifically seek out children and may abuse many children.

We understand that there are now proposals to add a basic child protection course to the training programme which course would be undertaken by residential staff in conjunction with others. We do not have details of this programme but assume it would concentrate on identification of abuse and child protection procedures.

**RECOMMENDATION 8** We recommend that additional training for staff in issues such as direct care of children including physical contact with them, sexuality, child abuse and the care of children who have been abused, should be made available as a priority.

(IV) INDUCTION

We have recommended in the section of this report which deals with recruitment that consideration be given to providing an extended programme of preparation and selection of new staff coming into residential work with children.

We understand that a previous induction programme for staff joining the department as Residential Care Officers is now not used and that there is no Regional programme for induction of staff in place,

induction being the responsibility of the Unit Manager. The new members of staff to whom we spoke described a variety of experiences. Some had had little structured introduction to their work and indicated they felt they had been left to muddle along and pick things up as they did so, others had had a clear programme to follow. For many the core of the experience was "shadowing" an experienced colleague; a method often referred to in training circles as "sitting beside Nelly".

We consider that the first days, weeks and months are critical for new members of staff for the acquisition of attitudes and skills as well as knowledge and more consideration should be given to the early training of staff. The elements of such a programme might include structured discussion and supervision within the Unit, and also more formal training outwith the Unit. There is a case to be made for all new staff having an initial period of formal training before joining the staff complement of the Unit at all.

In our discussions with newer members of staff, frequent mention was made of various documents, both by the staff and by ourselves. Some staff had studied and discussed the Care and Control document for example; others had not heard of it and did not know what it contained. Worryingly some staff indicated to us that they had had no basic training about these issues, albeit that they were required to exercise control over the young people from time-to-time. Some staff indicated to us that the Procedures Manuals and other documents which they would like to have consulted were missing or otherwise unavailable so far as they were aware. On the other hand, several staff commented that they had had an opportunity to study various documents and an opportunity to discuss the contents. In particular, two members of staff mentioned the "Standards: Residential Child Care" document and how much food for thought it had given them and how useful they had found the opportunity to reflect on its contents.

Overall the impression formed was that newer members of staff welcomed the opportunity to have materials to read that informed their work.

**RECOMMENDATION 9** We recommend that consideration should be given to the induction programme for new members of residential care staff. We recommend that a programme of training should take place early in a staff member's career and that consideration should be given to some training before staff join units at all.

**RECOMMENDATION 10** As a corollary to the training programme we recommend that all units ensure that the relevant Procedures and other documentation are available within the Unit and that all grades of staff should be expected to know the contents and incorporate them in practice.

(v) **IN STAFF TEAMS**

We note the focus in the Departmental training programme on training for individual members of staff. In regard to issues such as physical care, sexuality and unit cultures, we would suggest there is room for the development of training models for staff teams where the whole team trains together. We have not found the need for teamwork of this kind to be articulated particularly clearly in any of the documentation we have seen and we wonder if sufficient priority has been accorded to it. We did find examples of Units where attempts were made to provide such training. The staff were keen to develop this further but reflected on the difficulties presented by freeing whole staff groups in this way without detracting from the care of the residents. We understand discussions are in progress in the Planning and Co-ordination Section of the Department to take these issues forward and that the need for training for entire staff teams in this area is recognised. If Unit training is not valued, looked for, and given credit within management and inspection we suspect it may not take place.

**RECOMMENDATION 11** We further recommend that consideration should be given to the need for some of this training to be undertaken by whole staff teams.

(E) **MANAGEMENT OF CARE**

(1) **NEW MANAGEMENT STRUCTURE**

The Department has only just completed a major re-structure. At the time of the incidents which gave rise to the trial management of residential units and the responsibility for staff vested in the large Residential and Day Care section, headed by an Assistant Director, supported by Principal and Assistant Principal Officers. Responsibility for Units now rests in the 7 District Managers. The Director's report to Committee dealing with the matters which gave rise to the trial cites the new structure as an element which might assist in the early identification of any similar future incidents. There are a number of elements which point to that being a valid conclusion.

During our enquiries we were presented with much information which suggested that the Residential and Day Care Section was a reactive rather than pro-active organisation. The then Assistant Director indicated to us that there were a number of difficulties, including the large number of Units; difficulties in obtaining consistent levels of staffing of quality and reliability; the constant turnover of staff; the continuous pressures of the work; the time of management being so taken up with the recruitment and dismissal of staff; dealing with emergencies; that the Section had to deal with more disciplinary issues and tribunals than any other Section. Hence it had never proved possible

to plan ongoing training and professional development in any way which would approach the ideal.

A number of our respondents suggested that conscious or sub-conscious efforts were made to keep matters away from Directorate. Some of these attitudes arose from a well-intentioned attempt to carry out their own responsibilities without troubling management; some it was suggested to us, arose from concern about the way in which they thought management might react if they learned of the situation. For whatever reason the section did not appear to be well-equipped to hear complaints by residents.

Clearly the switch from a large Residential and Day Care Section to 7 Districts will now mean that the previous responsibilities will be split eight ways, 7 Districts plus centrally managed units. The problems will not go away; the switch does not eliminate the problems of staffing, recruitment etc. Indeed we have suggested in the section of this report on Recruitment, that de-centralisation may in some ways add to the problems. Further, some of our respondents suggested that what they perceived as the negative elements in the former Residential and Day Care Section are likely to persist through the recruitment of staff from that Section to new responsibilities within the Districts, in that those staff will take their negative experiences with them.

We are not alone in being conscious of disquiet amongst practitioners who are now striving to cope with the impact of major changes arising from the re-organisation. A number of these practitioners for a variety of reasons view the change with anything but enthusiasm. Despite that, in looking at residential units we visualise a very real potential for growth of professional development and satisfaction in the field of residential care. District and Service Provision Managers have responsibility for a limited number of Units. In most of the 7 Districts the number of units for children will be two, though one District will have three Children's Units and one only one. The centrally managed units, which include the two residential schools, have an individual management structure. We would anticipate that practitioners would find that a more direct personal responsibility for the young people would be an aid to effective management and provide the opportunity for these young people to be recognised as individuals with individual needs in a way which was never possible under the previous Residential and Day Care Section. In that connection the very nomenclature formerly universally used throughout the Department of "children's res" is anything but an attractive, stimulating title for a unit with responsibility for provision of high standards of residential care for children. It would be a sign of improved morale if this demeaning term were consigned to linguistic history.

## (II) RESIDENTIAL REVIEW

Reference is made in the introduction to this report to the Residential Review in Lothian. At the time of our report residential units were just

concluding the process of recruiting the new enhanced staffing levels and staff teams were beginning to consolidate. We found indications of raised morale, a sense of "a fresh start", energy and impetus to improve the practice. It was less easy to assess if this energy could be sustained and channelled creatively over time or whether it was a passing phenomenon of the reorganisation.

We particularly noted a number of pieces of work being done locally, for example, schemes for staff supervision, a training audit, recruitment schedules. Mechanisms to share such creative development across the divisions do not yet appear to have been put in place. There may be a danger both that practice could become unacceptably diverse, and that opportunities to capitalise on and sustain improvements in practice from within the Region could fail to be taken.

**RECOMMENDATION 12** We recommend that discussion and sharing of developments in practice across the divisions and the central units be encouraged, and that consideration be given to putting arrangements in place to enable such discussion and sharing.

(III) THE ROLE OF FIELDWORK

One major potential benefit arising from the restructuring lies in the role of the fieldworker. One of the glaring features of the abuse which gave rise to the High Court trial was that only one of the young people made any complaint about that abuse to her fieldworker.

During our meetings with young people in regard to our current remit we did not have much sense that the young people saw their fieldworkers as being particularly relevant to their needs and situation. It did appear that for some, once they were in care, their perception was that control passed to the residential staff. When we asked to whom they would complain very few mentioned their fieldworker. Asked why, the reply was along the lines "she's OK but couldn't do anything" [translated by us as "nice but ineffectual"] and that was one of the more positive responses. At one time it appeared that, where social workers left the Area Office, the priority afforded to allocation of cases of young people in care to a new worker was very low. Such a practice would no doubt add to the sense of where the "power" lay.

Equally worrying was the experience of the young person who had been a victim who volunteered to assist our enquiry. She had, we understand, been in care at her own wish, seeking sanctuary from abuse at home. She liked her social worker. She found she could not speak to her about incidents because she would have been too embarrassed to do so. It appeared that she had been able to talk about abuse within her own home but unable to speak about abuse within the residential unit.

We are conscious that these paragraphs do little to add weight to our conclusion that the new structure, particularly with the problems that

fieldworkers now face arising from the re-structure will be an improvement on what has gone before. Nonetheless the new situation does provide real POTENTIAL for residential and fieldworkers to work much more closely towards good levels of care for the future. The District Management structure provides the opportunity for a joint approach.

**RECOMMENDATION 13** We recommend that the District Managers make a priority of ensuring allocation of cases where young people are in residence; that fieldworkers as part of their responsibilities make it clear to young people who are about to be placed in care or those who are in care that they are available and would wish to hear about any issue of concern that may arise for the young person as a result of their being in care; that fieldworkers recognise that up till now in many instances (despite their protestations about "good relationships") that they have not provided an effective outlet for such matters and should use that recognition to work out how best they can provide for that contingency in the future.

#### (F) RECORD KEEPING

##### (1) GENERAL

A clear and careful record of a complaint is an essential element of the Complaints Procedure. Apart from the investigation of the individual complaint, such a record could in certain circumstances be relevant to the investigation of a subsequent complaint. Apart from the complaint itself a record may have a relationship to the issue of recruitment. Reference has been made earlier to the dangers of over-reliance on police checks and that this may induce a false sense of confidence. Information on individuals who have previously worked in the Social Work Department might, in any event, provide a more reliable guide. At present there appears to be no consistent practice as to what information is kept on staff and former members of staff. There are also considerable restrictions on what information may be permitted to be retained.

It is a matter of record that the employee who was found guilty of the offences in the High Court had been the subject of previous complaints prior to the final one which led to his being charged. Reference is made in another part of this report on the way in which the previous complaints were dealt with, reflecting on the possible inadequate way in which the investigation took place at the time. In the actual Court proceedings, the accused was finally convicted of charges through what is known as the MOOROV principle. Briefly stated that principle allows individual acts to corroborate each other, albeit there is only one individual to speak to each individual act provided that the acts are



sufficiently connected in time, nature and specification to warrant corroboration.

Incidents or alleged incidents may be recorded in three different locations:

- a. **The child's file:** Any allegation would be bound to be recorded and retained in the child's file. The result of any investigation which followed the allegation would also be included together with the care steps which had been taken for the young person in respect of the allegation. Such information would stay with the child's file. It would be difficult to draw upon that information if it were required in the future. The ability to do so would depend on the presence and memory of key individuals.
- b. **The Unit Record:** It is understood that there has been lack of uniformity of maintenance of Unit Records but that this issue is currently being addressed by management with a view to achieving uniformity. Allegations of complaints should be retained within the Unit Record but as with the following section there are considerable restrictions on what information may be retained. A record of a complaint against an individual member of staff might assist the management of that unit or indeed District but as with the case of children's records such information would be of limited value in regard to an investigation where a member of staff was now employed in another Unit or District.
- c. **The member of staff's file:** In keeping with overall Lothian Region practice and principles of employment legislation there are severe restrictions on what information may be retained in a member of staff's file where an allegation of misconduct has been made.

## (II) EXAMPLES OF ALLEGATIONS

A number of possible examples are instanced using, for these purposes, a situation where a child made a complaint against a member of staff of indecent assault.

1. **Unsubstantiated Allegation:** The member of staff denies the incident. There is no other possible information available apart from the two conflicting accounts. In terms of the current Complaints Procedure the complaint is competently and thoroughly investigated. The investigation involves the Police. Despite the careful investigation of the complaint it would be difficult, if not impossible, for any action to be taken. This is the first time such a complaint has been made against that member of staff. For the purpose of this exercise the assumption is made that the child's complaint is valid but the "guilty" member of staff supports his

denial by pointing to previous unreliable accounts given by the child in regard to unrelated matters and allegations as to the child's animosity to him and her awareness of the potential power she had to "get back at him" in support of his denial. At the conclusion of the investigation a decision is taken that there is insufficient evidence to substantiate the allegation. No record of that allegation can therefore be maintained in the member of staff's file (though presumably the fact that the child had made the allegation and the fact that it was unsubstantiated would remain on the child's file).

2. **Inconclusive Disciplinary Proceedings:** On the assumption that perhaps marginally more information was available, then the accounts of the complainant and the member of staff disciplinary proceedings are embarked upon. These proceedings fail to reach a decision that the member of staff is at fault. All records relating to the incident so far as the member of staff was concerned would fall to be expunged.
3. **Appeal against Disciplinary Proceedings Decision:** As with the previous example, a decision is taken that the grounds of complaint are substantiated. A decision follows. The member of staff successfully appeals to the Council against that decision. Again the record would require to be expunged.
4. **"Spent Conviction":** Whilst it might perhaps be anticipated that in the kind of situation that has been instanced, a member of staff might expect to be dismissed on admitting the allegation or its having been established at disciplinary proceedings, such a disposal would not necessarily follow. In such situations if another disciplinary decision were taken such as a Final Written Warning, then after the appropriate statutory period that entry and the matters that gave rise to it would require to be expunged from the member of staff's file.
5. **Resignation:** The Managers feel that the allegation is in all probability accurate and already have concerns about the member of staff's competence and ability in their area of work but doubt their ability to produce sufficient information to warrant formal proceedings. The member of staff challenged about the allegation affects high dudgeon and indicates that given the management's response he is tendering his resignation. There is readily understood relief on behalf of management to accept this resignation and to feel that the matters have been resolved. There is no certainty that the personnel record would include information as to the reason for resignation. After a period of time if that former member of staff applies for employment perhaps in another District, there is no certainty that the records would disclose the previous incident if he

chooses to disclose his previous employment. If he fails to disclose information relating to his previous employment, it is even less likely that there would be any awareness of the previous incident.

6. **Withdrawal of a complaint:** A more common concern might relate to a child making a complaint which is subsequently withdrawn. As commented on in another part of the report, young people can be influenced by a number of factors to withdraw complaints even although they are true. It is not hard to imagine the relief felt by Management of the Unit, or District that the withdrawal of the complaint has resolved the problem. The member of staff is able to show to colleagues and others how justified his denial has been.

(III) **STAFF RECORDS AND EMPLOYMENT POSITION**

It seems contrary to natural justice to suggest that any record of a withdrawn or unsubstantiated complaint should be maintained in the member of staff's file. Staff members and their managers have reflected to us their unease that their employing department be permitted to retain sensitive, critical, unsubstantiated information. Their concerns are readily understood.

Those staff members add to their concern their view that many of the young people can, on occasions, be unreliable and that if they were aware that such information could be retained, that this would give them an inappropriate sense of power. We have already reflected that a number of staff have a sense that the operation of the Complaints Procedure and the emphasis that the Department places on this means that Managers are more prepared to listen to "unreliable children" as opposed to "trusted adults".

Yet the inescapable fact remains that as the law now stands it would be possible for a criminal court to convict an accused person on the beyond reasonable doubt standard in situations where the Department might be unable to dismiss that employee or take any action against him on the basis that they only had information relating to a single incident which, taken by itself, gave insufficient information to establish the complaint even on the lower standard of the balance of probability.

Regional Regulations relating to these matters properly recognise that as good employers the Region will not keep black lists or records which include information which is critical of staff members but which management are not in a position to substantiate. That said, the Regional Personnel Manager recognises the particular responsibilities which fall on the Social Work Department and has indicated that it is possible for individual departments to make their own case to the Council as to why they should be excepted from the general Regional Policy and rule.

The Warner and Skinner Reports and other Reports relating to child care and Government guidelines to Regions as employers point to the critical responsibilities which Authorities embrace when they, often through the exercise of their statutory powers, take on the care of their

residents. Countless child care enquiries point to the expectation of the safety of the resident and stress how carefully prospective staff should be vetted and recruited. It is submitted that the Council should not seek to tie the hands of the Social Work Directorate by allowing the balance of the rights of staff to prevail when these rights might operate to the detriment of children. If the Department is not able to maintain records of unsupported, inconclusive or withdrawn allegations made by individual children of the nature exemplified earlier in this section, the ability of the Department to protect children will be restricted.

While the Council might be reluctant to consider such a change, this Report suggests that the Social Work Department endeavour to argue a case as to why information on staff, who are involved in residential care, particularly for children (though many of the same principles apply for those in charge of the elderly or groups of less capable adults) should be retained in a different way from those which apply to other Departments of the Region. It is conceded that the Education Department may have similar interests in some regards.

**RECOMMENDATION 14** We recommend that the Director of Social Work enter into negotiations with the Personnel Manager and Regional Solicitor to adopt a specific Policy for retention of information on current and former members of staff.

We have acknowledged that this recommendation is likely to be met with staff suspicion and opposition. If it is taken up we are confident that the Department and Personnel Manager would, from the outset, appropriately involve the Trades Unions in the discussion of the sensitive issues involved. We would not wish to be over-prescriptive about how the retention of information should be achieved since we appreciate that these issues would be better addressed on a consultative basis rather than our attempting to set out guidelines.

We would, however, suggest that a realistic approach would be for staff to know from the outset of their employment that information would be retained and that the information could include information about any allegations which had been made, including the decision as to how they had been disposed of. More positively the information would also include evaluation of the member of staff's competence, enthusiasm and aptitude for the work. Such information would be available for the Department for any member of staff who left but subsequently applied to be re-employed.

The information retained should be based on the ongoing assessment which took place from the period of employment and would include as a key factor, the relationships which existed between the member of staff and the residents. Even if there had been difficulties over one or possibly more residents, that information by itself would not be inappropriately held against an applicant aiming for re-employment or promotion.

When, however, the concerns were real and a member of staff had been found to be less than well fitted for the task, the availability of this information would be of assistance in regard to the general provision of protection of residents.

Such evaluations should be made at the conclusion of each member of staff's employment whether by resignation or for any other reason, no matter how long or short the period of employment might have been. Any approach for employment should be checked against these records. For anyone other than a person who had changed his or her name that record should form a valuable piece of information for those who are seeking to recruit and should be of benefit to those staff who have shown that they were capable of carrying out the work. It would be a much better record than that based on anecdotes or failing memories.

The location of such a record within the Department and the entitlement to examination of the information contained therein, would be a matter requiring ongoing consideration and consultation.

## (G) INVESTIGATION

### (1) BACKGROUND

In addition to considering the case which initiated our enquiries we have also been made aware of a number of other investigations conducted at various levels recently and currently. We have looked at the records in a small number of these and have heard others described to us in detail by those involved.

As we collected information for this report, we became aware that a common feature amongst the cases which we discussed which had eventually been brought to a conclusion by disciplinary and/or criminal proceedings being taken against members of staff, was that there had been earlier attempts by young people to articulate complaints which had not been followed up. Sometimes an almost chance remark had led to a matter being picked up and followed up appropriately. Since complaints by children will continue to be articulated in this oblique and tentative way, it is essential not only to enable young people to articulate their concerns, but also that the department has the will to take matters forward. The cultivation of an attitude of valuing young people and embodying those attitudes in the work of the Department is an essential underpinning of appropriate investigation.

Staff then have to know how to carry out a thorough and competent investigation. The inter-relationship of Procedures may be very complex.

We identify elsewhere that, even if the Complaints Procedure has been the method by which the matter is originally articulated, where the complaint relates to abuse or misconduct the Child Protection Procedures and the Discipline Procedures of the Authority, together with criminal investigation by the Police, may well be the most relevant Procedures in the investigation process.

We recognise that conducting investigations of this kind is an intellectually and emotionally demanding task. There are always the problems of the emotional impact of the material, and the investigator may become emotionally involved with the enquiry. Intellectually it is necessary to avoid jumping to conclusions and to marshal all the evidence carefully for and against the allegation which is being made.

It was represented to us by various respondents that the atmosphere within the previous Residential and Day Care Section was not always conducive to the open acknowledgement and resolution of difficulties. We have commented on this aspect elsewhere in the report. Clearly in such an atmosphere the investigation of alleged shortcomings and malpractice by staff becomes an even more difficult task and the cultivation of open, mature and secure professional attitudes throughout the Department is important in this area as elsewhere.

The case which initiated our enquiries showed evidence of inadequate investigation at earlier stages. Corroborating witnesses were not sought out and matters were not referred to the Police until the final complaint of the series came to light in 1991. As we have noted, we were also made aware of other recent and current investigations, some of which led to other proceedings. We have not examined any of these systematically or in detail but we have looked at some examples of enquiries and heard others described. In one at least there appeared to be glaring omissions in the conduct of the investigation. We have formed the view that the standard of investigation is variable.

We have not found a complete guide for staff on how to carry out an investigation. It may be that it would be helpful for more specific and extended notes to be prepared and training offered in this particular area of work.

(II) **STAGES**

From our work it appeared that a system which embraced the following stages would be an advantage:

- a. **Making a note of the complaint and clarifying it with the complainer.** The stage of taking a statement or interviewing the young person is usually identified as critical. Cross-reference can be made here to the interviewing guidelines for joint interviews by Social Work and Police in child protection cases, which provide a useful framework both for the internal validation of such statements and the ways which such enquiries can most effectively be put in hand.
- b. **Seeking other witnesses and circumstantial evidence.** Quite often other children or staff have seen something of what has gone on especially where allegations concern several contacts between the staff member and the child. We have noted that investigations do not always consistently and systematically seek out other witnesses who may have

statements to make. There may also be circumstantial and other evidence which needs to be collected particularly if time has elapsed since events are said to have occurred. Obvious ones might include checking rotas and Unit Logs and it may help to visit the place where the incident is said to have happened.

- c. Seeking out records of similar events or incidents recorded about the same person. The importance of cross-referencing cannot be over-emphasised. In the section entitled "Record-Keeping" we discuss the "MOOROV" principle where separate similar incidents may be held to corroborate each other, and the need to keep systematic records of allegations.

It is also important to keep records of complainers since it may well be, for example, that a young person may display a pattern of behaviour which includes the making of allegations against carers or others and it would be important that staff were able to have access to such information at an early stage in their enquiries.

- d. Considering whether to seek out corroborative events or incidents which have not been logged. For example it might be that other young people who have been living in the same unit and who have made no complaint about a particular matter, may be interviewed about their experiences. We understand that this was done by the Police in the case which initiated our report. It is always a delicate matter to decide when enquiries have got to the stage when this breadth of enquiry is necessary but the matter requires to be addressed.

**RECOMMENDATION 15** We recommend further attention to the preparation and training of staff in investigation.

**RECOMMENDATION 16** We recommend consideration be given to preparing notes of guidance for staff involved in investigation.

(III) MANAGEMENT OF AN ENQUIRY

Within the Department there is a need to correlate the investigation of complaints. Adherence to the Complaints Procedure will ensure that all complaints are logged centrally. That said, a complaint by a young person which involves an allegation of abuse or malpractice by a member of staff would not then be investigated within the Complaints Procedure. The Child Protection Procedures would operate if relevant (one has to allow for the case where the young person might now for example be over sixteen and left care before the complaint was raised). If the Child Protection Procedures were invoked these would include referral to the Police. Consideration would also require to be given to

invoking the Staff Discipline Procedures and to referring matters to the Police as a possible criminal enquiry. The matter may also require to be drawn to the attention of the Registration and Inspection Unit, although we suggest that the direct primary investigation of a complaint by a young person would not usually be their role. In an attempt to illustrate the complexity which can be present and variety of tasks which may need to be addressed we have elected to provide two hypothetical examples of situations which might require investigation in APPENDIX C, with our observations thereon.

(IV) APPOINTMENT OF THE INVESTIGATOR

We considered particularly the role of the Service Provision Manager, since we understand that at present in most cases that individuals would be expected to make the first investigation of complaints unless there was clear reason why that was inappropriate.

It has been reflected to us by some Service Provision Managers that they appreciate that they could be subject to conflicting loyalties and demands in that setting. Others might appear to take exception to suggestions that they might lack the essential objectivity. The Service Provision Manager has close management responsibilities for children's residential units and other units and may well have close contact with the member of staff complained about, close contact with the young person who is making the complaint and be involved in the processes which are being complained about.

The view of young people also has to be considered. Young people made it very clear to us that they would wish to voice their complaints to someone they know and trust and who they believe to be an effective person. In some cases this might well be the Service Provision Manager whom many of the young people within Lothian units know and respect. One could however visualise a situation where the young person wished to complain about a senior member of staff within the Unit, for example the Unit Manager, who could be seen as being an ally or close colleague of the Service Provision Manager. It could be that young people would be deterred from making any complaint known even to an outside Children's Rights Officer or Complaints Officer, if they thought that the normal pattern for investigations was that they should be completed by the Service Provision Manager.

Whether or not Service Provision Managers have the objectivity necessary to carry forward a particular enquiry is not the most important issue. We think it should be borne in mind, when a person to conduct an investigation is to be appointed, that there should be a climate recognising that independence in the investigation is important.

**RECOMMENDATION 17** We recommend that at an early stage the Department should identify who is to carry out the investigative responsibility within the Department, who is to monitor the enquiry and what arrangements should be made to enable these matters to be addressed consistently.



**RECOMMENDATION 18** We recommend that serious consideration be given in any case where abuse is alleged, to the need to demonstrate the independence of an investigation. That consideration should include the possibility of locating the enquiry outwith the District, or including in the investigation team a member of staff from outwith the District.

(v) **DISCIPLINARY ENQUIRIES**

Enquiries under the Staff Discipline Code were made in the case with which we were concerned on two occasions. The enquiries in 1991 which led to the High Court trial began in this way. The staff Discipline Procedures within Lothian Region are much more developed now than they were in 1985/86 when Disciplinary proceedings were taken which proved abortive. During our enquiries observations were made to us that more thorough investigation of the original allegations made in 1985 might have resulted in a different conclusion.

The Regional Code provides, amongst other things, for the appointment of an Investigating Officer and for various procedural safeguards. We have noted the availability at Regional level of training in regard to these procedures and the conduct of investigations. It would be desirable that staff conducting investigations which are, or may become, disciplinary in nature, should take up such training.

We particularly noted the expertise in this area of the Senior Employee Relations Officer of the Social Work Department. We are aware that with the location of enquiries within the Districts and the location of the Senior Employee Relations Officer at Shrubhill, the ease of communication and indeed personal acquaintance which arose previously when the Residential Section Senior Officers who were likely to be involved in enquiries were also located at Shrubhill, will not now obtain and it may well be that a more formal requirement for consultation needs to be acknowledged and practice developed in this area.

**RECOMMENDATION 19** We recommend that regional training for staff conducting disciplinary enquiries should be taken up by all staff conducting such enquiries.

**RECOMMENDATION 20** We recommend that in any disciplinary enquiry the Investigating Officer should consult, at an early stage, with the Senior Employee Relations Officer and continue regular consultation thereafter.

(vi) CONTACT WITH THE POLICE

A THE PARTICULAR CASE

The case which proceeded in court was of course fully investigated by the police. It seems that they were not involved in the earlier investigation which culminated with the inconclusive disciplinary proceedings in 1985. They would have been had the child protection guidelines been followed, since these guidelines include a requirement to notify the police – “in all but the most insignificant cases the police must be informed where there are reasonable grounds to suspect that an offence has been committed even if this is not known by whom”.

While the police officers to whom we spoke were clearly reluctant to criticise officials of another organisation, and we did not wish to press them in this regard, we detected a sense that they would have wished to have been involved in regard to the earlier allegations, that they experienced real difficulty in obtaining relevant records of past allegations (as we have noted this is not surprising), and a reluctance on the part of some workers to be as positively helpful as they might, possibly attributable to their own feelings of having failed to take action which might have protected the victims. That said, the police were quick to acknowledge the very real and positive efforts that some members of the department made to assist and further their enquiries.

What was very clear was the very real support and protective role which was taken by one key female investigating officer to the witnesses. The correspondence which we sent to them was via this police officer. The one witness who subsequently spoke to us, (she had not been without difficulties with the police in the past) and all members of the department who had direct knowledge of the case left us in no doubt as to how much the witnesses appreciated the way in which the police had carried out their investigation and the way in which they had provided reassurance and support.

The police shared the concern of others to whom we spoke about the inadequacy of the preparation for giving evidence and the lack of support in the court setting. As witnesses themselves there was a limit to what they could do, certainly for the young people who had completed their evidence as they (the police witnesses) had still to be called. They would welcome early clarification of these responsibilities in any future case. For example, in cases where the department is not involved, the Woman and Child Unit has often taken a lead role, with the knowledge and approval of the prosecuting authorities, in regard to a pre trial visit to the Court. They

would be glad to discuss with an appropriate officer from the Social Work Department how such issues would be best dealt with in the future on an individual basis.

B

#### ADVANTAGES OF REFERRAL TO THE POLICE

Quite apart from the requirements of the Child Protection Guidelines to notify the police, such early notification would be a positive way of assisting the investigation of any allegation that a child has been the victim of an offence. While the trial which gave rise to our remit arose from allegations of sexual abuse an approach to the police would be equally relevant, indeed essential, where the allegation was one of physical abuse or assault.

The police are experienced, trained investigators. They provide an independent enquiry as opposed to the Social Work Department investigating themselves or their colleagues. While it may be that some residents may not be particularly well disposed to the police in general, they do understand the particular investigative role which the police have.

The police have a good understanding of the respective standards of proof for criminal and child protection proceedings (they also have an awareness that the lower standard applies to any disciplinary proceedings which may flow from their enquiries). The police have a proven track record and interest in pursuing child protection issues. If at one time it might have been suggested that their only interest lay in cases which were to be prosecuted that has not been true for a very long time.

The early involvement of the police would be an extension of the good practice and increasing professional respect embraced by the Social Work Department and Police Force in the recently publicised guidelines relating to the joint interviewing of children.

C

#### ARRANGEMENTS FOR REFERRAL

The police representatives to whom we spoke indicated that they would welcome such an approach being adopted. They have suggested that the best approach would be that the referral be made by a key person in the Social Work Department to the Chief Inspector of the C.I.D. of the Police Division in which the suspected or alleged offence has taken place. They have suggested that it would help consistency of practice if the number of referrers was restricted in this way. If that was accepted then perhaps the relevant Service Provision Manager might be the named person. A person appointed as Investigating Officer by the Social Work Department might therefore refer through the Service

Provision Manager. The police enquiries would in most cases be conducted by officers of the Woman and Child Unit.

The police have also indicated their willingness to make themselves available for discussions in marginal cases as to whether or not they should be formally involved. Such an offer could be of considerable assistance to a person charged with the responsibility of investigating an allegation. These opportunities would work best where the number of people involved in the referral process was restricted and such an approach would be difficult if every Unit Manager and Assistant Unit Manager, or fieldworker were free to communicate in this way with the police. That said, it is appreciated that in an urgent situation any of these persons might be required to notify the police of an occurrence.

The actual details of communication would require to be the subject of agreement between the Social Work Department and the Police, which could follow the recently established guidelines for joint investigation.

**RECOMMENDATION 21** We recommend that the potential of the Police to assist the investigation process and those involved therein be recognised and utilised.

**RECOMMENDATION 22** We further recommend that discussions take place between the Social Work Department and the Police service to put in place detailed working arrangements to facilitate future co-operation along the lines described in the paragraphs above.

(VII) **FEEDBACK TO COMPLAINANT**

The young people who had earlier complained in the case initiating this enquiry had not heard the outcome of their complaints. A frequent comment made to us by the young people to whom we spoke about current matters, was that they never hear or see any results from any complaints they make. These are not usually complaints about abuse, or formal complaints under the Procedure, but relate to other matters, usually connected with the running of their Unit. This encouraged some young people to believe that it is useless to complain as nobody ever listens and nothing ever happens, and a number of them said this forcibly to us.

We note that the Complaints Procedure now provides that complainants are kept advised of the conduct of the enquiry and should hear a result of their complaint. It appears to be axiomatic that complainants should be treated in this way and that young people

should have support, and be kept up-to-date with the progress of the enquiry particularly if that is a protracted enquiry.

The Complaints Procedure provides for the feedback of the outcome of the complaint, although it may be that communication by personal contact as well as formal letter would be desirable in the case of young people. Where the Complaints Procedure in a particular case has been suspended to allow for other procedures to go forward, such as Child Protection, Staff Discipline and Police enquiries, it may be that the need to provide information of this kind would not be so clear.

Young people need to know the result of their complaints. Further, where the Department reaches the conclusion that the Department, through the actions of a member of staff, has caused harm to a young person, it appears to us to be crucial that the Department acknowledge that responsibility to the young person. Failure to do so may impede the task of continuing appropriately to care for the young person. We recognise that such a practice might conflict with advice given by the Region's Insurers and by Legal Services.

**RECOMMENDATION 23** We recommend that the Authority, in co-ordinating investigations of this kind, should ensure that the young person is kept informed of what is happening and of the eventual outcome of the matter. This consideration should also extend to staff who raise complaints on behalf of young people or who enable young people to have their complaints heard.

(H) FOCUSING ON THE CHILD

(I) GENERAL

In our consideration of the Complaints Procedure we were struck by the various considerations with which practitioners required to contend. Given the current emphasis on these procedures being carried out effectively, it is perhaps not surprising that staff become very anxious about doing everything right. We have acknowledged that in the kind of case which gave rise to our remit, the issue of giving information in respect of a colleague presents particular conflicts for the practitioner. In these circumstances, we detect that there may be a danger that the critical issue of protecting the child may become a secondary role to that of "getting the procedure right". In the case we examined it did not seem that the needs of the child were always the priority and indeed on occasions they became subservient to the needs of the procedures.

(II) CHILD PROTECTION GUIDELINES

In the case which gave rise to the High Court trial, although on a number of occasions children had given information about alleged abuse, on none of these occasions had use been made of the Region's own guidelines including the essential convening of a Case Conference to decide what action should be taken. We learned that in other past cases

where such allegations had been made by children in residential care, the practice required by the guidelines had not been followed.

Respondents impressed on us and we accepted the absurdity that where a young person living within his or her own home alleged abuse, the allegation would be examined on a multi-agency basis with a Case Conference and a real priority given to considering what was best for the child, yet such procedures had not been deemed appropriate or necessary when the child was in the care of the local authority.

It was suggested to us that some young people, particularly mid-teenagers, would not wish such allegations to be the subject of a Case Conference with a variety of adults to pore over sensitive personal allegations and that such Conferences constituted an intrusion of privacy. Whilst we understood these issues they appear to be us to be equally valid for children who are not in care.

**RECOMMENDATION 24** We recommend that in future when any allegation of this kind has been made that an appropriate Case Conference be called.

Such an approach would have a number of advantages. It would provide a focus for the individual needs of the child as opposed to the procedure and it would detract from the perception of the Social Work Department examining itself. It would involve in most cases referral to the Police. There would be involvement by other relevant services including health and education. We do appreciate that Child Protection Procedures might not require to be involved in certain cases such as those where a young person now over the age of 16 had returned home from care and subsequently made a complaint about maltreatment whilst in care.

Fortunately the incidence of such Case Conferences would be likely to be few in number. The Regional Co-ordinator for Child Protection has indicated that he would see such a remit to him as being an appropriate one for his functions and one which he would be prepared to discharge. While not wholly independent, since he is a member of the Social Work Department, he would be someone who did not have conflicting responsibilities such as those which would fall on a Service Provision Manager or other staff member from the District where the alleged abuse occurred and this "independence" would be an aid to objectivity. While it would be possible to arrange for appointment of an officer from another District, we would commend the use of the Child Protection Co-ordinator as one which would aid clarity and help establish a consistency of approach.

**RECOMMENDATION 25** We further recommend that where the Child Protection Guidelines were being invoked that the Case Conference be convened by the Regional Co-ordinator of Child Protection.

(III) **SUPPORTING THE CHILD WHO HAS MADE AN ALLEGATION**

Just as reporting procedures produce dilemmas for staff so does the act of reporting the incident create a potential heavy burden for a child. The child may experience a mixture of emotions; there may be peer group pressures; the incident itself (or series of incidents) may have been particularly distressing. It seems unnecessary to go into further detail regarding that matter.

There is a need as soon as a child makes an allegation that a suitable person be appointed to consider the ongoing needs of the child as opposed to the investigation of the complaint. It should be the responsibility of the Service Provision Manager or District Manager to ensure that such identification is made and that the responsibilities are carried out. In making the decision as to who to appoint, the principal guiding factor should be the wishes of the child. It would not of course always be possible or appropriate for the child to be able to nominate the individual. For example, the person of the child's choice may already be so tied up with the Complaints Procedure to have the necessary time and objectivity to carry out the necessary duties.

Part of the consideration of the interests of the child should be the child's place of residence. Just as removal of a child from a family home on the basis of alleged abuse can constitute a punishment for the child, so the removal of a child to another unit as a result of the disclosure could add to the child's unhappiness. The situation within the unit however, including the attitude of other residents and possibly members of staff, might combine to make continuous residence there so uncomfortable as to make that contra-indicated. What this section suggests is that in each case priority be given to the particular individual needs of the particular individual child while the Complaints Procedure/Disciplinary Proceedings/Police investigation and any subsequent trial take place.

**RECOMMENDATION 26** We recommend that when a child has made an allegation of abuse, a decision be taken to identify a key individual who would have paramount responsibility to provide appropriate support to the individual child.

(IV) **SUPPORTING THE CHILD IN ANY JUDICIAL PROCEEDINGS**

A feature of the trial which gave rise to our remit was the initial lack of appropriate support given to the young people (and indeed staff) who required to attend to give evidence. The request to attend and give evidence at any proceedings constitutes at best a nuisance. For young people to have to give evidence and be subjected to cross-examination in a High Court trial where the allegations are those of a sexual nature in respect of the witnesses themselves, constitutes a very heavy burden. The case which we considered was a particularly distressing one for the young people concerned. It would appear that a number of factors

including the postponement of the original trial date and the departmental re-organisation, contributed to the lack of preparation and support which arose in this particular case. A further difficulty and one which is likely to continue to be so for some time until a nationally agreed code of good practice for such matters is drawn up, refers to a lack of clarity as to what does constitute good practice in regard to support of a witness and the dangers to a prosecution by inappropriate preparation – for example schooling a witness as to what to say. If our recommendation that a named individual be appointed to consider the ongoing needs of the child is accepted, then that remit should include support of the child through the trial process. The appointed person would require to take it upon his or herself to consider how best to do so in the light of the specific case and after discussion with senior staff, legal services, police or prosecuting authority. The duty to provide support should include preparation for the trial, support during the actual trial and support after the verdict.

Whilst the purpose of this report is to consider the Complaints Procedure so far as relating to children we feel obliged to add that in regard to judicial proceedings it is crucial that appropriate consideration be given to preparation and support of staff who may be required to give evidence. As with the young people the giving of such evidence has its own heavy responsibilities.

In the particular case it would appear that the preparation given to staff was less than adequate. So far as conditions of service are concerned we are advised that some staff members required to go straight from Court to normal shift duties after spending a whole day in the High Court. We would hope that in the future where staff require to attend Court for the purposes which obtained in the particular case, that managers give appropriate consideration to their being released from normal duties during the period when they are required to attend Court. Such arrangements are not in the interests of the staff members and arguably not in the best interests of the children who are in their care.

Staff witnesses should also be provided with appropriate understanding of what will be required of them in the Court process. Increased confidence and awareness by staff would help them re-assure the child witnesses. Anxiety on their part would be likely to be communicated to the children.

<b>RECOMMENDATION 27</b> When judicial proceedings arise from an allegation, we recommend that the key individual providing support to the child should provide appropriate support before, during and after the judicial proceedings.
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## (1) THE COMPLAINTS PROCEDURE

### (1) IDENTIFICATION OF A COMPLAINT

We discussed what is and is not a complaint with young people and staff on our visits to Units and found many examples of matters which might or might not be or become formal complaints into a Complaints Procedure. These included, "the laundry arrangements here don't work", "my next placement isn't coming up fast enough", "my property has been stolen, it hasn't been replaced, and the Department has not insured it", "the young people in this Unit are all angry at the staff being moved to other Units", "another resident had it in for me and the staff were not doing enough to help resolve the situation", "I am not allowed to telephone my girlfriend in private". These matters might be, and indeed sometimes were, resolved by the unit staff to the satisfaction of the young person.

Young People in residential care in Lothian have had the same right of access to the formal Complaints Procedure as other clients of the Social Work Department since the Procedure came into operation. We understand that remarkably few complaints from this sector are being received. There may be many reasons for this.

#### POSSIBLE REASONS WHY YOUNG PEOPLE DO NOT COMPLAIN

1. Young people are satisfied with the care they receive, therefore they have nothing to complain about.
2. Young people do not recognise that they have a complaint because they do not have enough understanding of what kind of quality of service they can expect.
3. Young people do not know how to make a complaint. More publicity will cause the number of complaints received to rise.
4. Young people are afraid to complain. They fear they may not be believed and that there will be uncertain and uncontrollable consequences for themselves, particularly that they will be victimised.
5. Young people do complain to staff and these complaints are being "edited out" and not heard properly.
6. Young People's complaints are being resolved informally and satisfactorily at an early stage without resort to formal Complaints Procedures.

We think that those who struggle to find an operational definition of a complaint, are dealing with a real problem. It is not helpful to isolate

“complaints” as something which can only be dealt with in a formal Complaints Procedure format – the response which could be caricatured as “I am not dealing with this, if you have a complaint to make, use the Complaints Procedure”.

(II) **PARTICULAR CONCERNS ABOUT COMPLAINTS FROM YOUNG PEOPLE**

Hearing young people, engaging with what they have to say and carrying it through is central to working with young people, particularly in residential care. We say more about hearing young people elsewhere in this report. That said, the boundaries about what must/should be dealt with in formal Complaints Procedures, are important and need further discussion and definition. From our standpoint the following at least should be included:

1. Any matter where a young person suggests that he or she has been assaulted or abused or the subject of improper conduct from a member of staff or other adult connected with a residential unit.
2. Anything which the young person wishes to make a formal complaint about. The client must have open access to the Procedure if he or she wishes.
3. Any matter which has not been resolved to the satisfaction of the young person in informal discussions. A sensitive balance is needed here between insisting that young people's complaints are logged formally and taking the decision away from them and enabling, rather than impeding young people to make complaints.

**RECOMMENDATION 28** We recommend clarification of which matters or issues raised by young people require to be processed as formal complaints.

(III) **PUBLICITY**

At the time of our report publicity material for young people in care about the Complaints Procedure was in process of preparation. The programme to distribute material and to conduct a publicity campaign involving leaflets, posters, contact with staff and groups of young people, had not yet been put in place.

As we visited various units we were shown various leaflets and brochures prepared by units to be given to young people and parents as part of the Admissions Procedure to the Unit. Most appeared to contain information about how a complaint should be made. The young person to whom we spoke, who had been involved in the original court case, and other young people, said to us that any leaflet should have clear information including the name and phone number of the persons to whom complaints could be made. Possible individuals and

organisations would be, the Client Services and Complaints Officer, the Children's Rights Officer, the 'Who Cares' representative. A very relevant organisation for children in care to be included in any leaflet is "Childline".

**RECOMMENDATION 29** We recommend that information should be made available to young people about the Complaints Procedure and that this information must include the identity of persons to whom complaints may be made and the telephone numbers of those people.

It appears to us that information about the Complaints Procedure should be given to families as well as directly to young people. Parents are the natural guardians of children under the age of 16 and can represent them in legal and other proceedings. We are aware that some children in care are estranged from their parents. Some children have very strained relationships with their parents, but even when relationships are difficult, parents have a right and a wish to be involved in the care of their children. Some children will speak to their parents about possible complaints and see them as their first and most natural confidantes and supporters. To enable parents to discharge their duties to their children, they must have full knowledge of the Complaints Procedures as they relate to their children. It has to be remembered that parental rights are only removed in Scotland by specific Assumption of Parental Rights, they do not pass to the Authority by virtue of supervision requirements or reception into care of a child under Section 15. Reference is made to the strong recommendations in the Skinner Report (Section VI) "Partnership with Parents".

**RECOMMENDATION 30** We recommend that specific information about complaints procedures be made available to parents of children in care.

(IV) **THE CLIENT SERVICES AND COMPLAINTS OFFICER**

We have had several meetings with the present Client Services and Complaints Officer for Lothian Region and have found the information provided and the discussions most helpful in our work.

The location of the post, reporting to the Senior Depute Director, or in his absence to the Director in person, can be seen to emphasise the importance attached by the Director to the matter of complaints. It also provides immediate consistent senior management oversight of all complaints arising.

Detailed analysis of the workload and management of the Complaints service lies beyond the scope of this enquiry. We were made aware, however, of the considerable pressure of work which has arisen and the difficulties, for example, in meeting the timescales for investigation. It

may be expected that when further publicity about the Complaints Procedure takes place that the number of matters coming to the attention of the Complaints Officer will rise. There may be a need to assess the pressure on the arrangements to deal with complaints.

Though we have reflected on the onerous nature of the post we learned that only a very small number of complaints formally referred to the Director come from young people in care. We noted earlier (p 45) some of the possible reasons for this. To these might be added staff distrust of the procedure, uncertainty as to its practical application, and unfamiliarity with the identity of the post holder. In that connection the current occupant has told us of how much she valued the practical experience of attending the trial for support purposes and her perception that her presence there made her and her duties more credible to staff.

The Complaints Officer is required to provide an Annual Report. The inclusion of a section in that report which dealt specifically with complaints by children who were in residential care would provide an admirable opportunity to ensure that the issues which gave rise to the High Court Trial and the instruction of this report were examined on an annual basis. Such a requirement would provide an opportunity to see whether the current low figures are a true reflection of the position. Without it the current good intentions and impetus to examine the issues and improve practice could be superseded by other subsequent pressing demands.

**RECOMMENDATION 31** We recommend that the Annual Report of the Client Services and Complaints Officer should contain specific information about complaints by young people in care and how these complaints have been dealt with.

We also noted the isolated nature of the post and the absence of opportunities for consultation and discussion with peer group colleagues. It may be that the overview and the development of the service would be assisted by the development of some kind of consultative support group which might include people from both within Social Work Department and from elsewhere to assist in the processes of reflection, analysis and planning which will be required to keep the service responsive to future demands made upon it.

**RECOMMENDATION 32** We recommend that the arrangements for dealing with complaints are kept under close review particularly in relation to the demands being made on the service and plans for its development.

(V) **STAFF TRAINING**

We consider that there is also an urgent need for training for staff not only in the details of the present procedural arrangements for the Complaints Procedure, the Children's Rights Officer, the Who Cares representative, function of Registration and Inspection and so forth, but also in the principles which underpin these introductions so that the efforts of the Authority to introduce these Procedures is made effective by their understanding and adoption by the members of staff at all levels.

Participation in Training Programmes by such as the Complaints Officer, Children's Rights Officer and 'Who Cares' representative might be hard to arrange because of their overall commitments but if this were possible their presence and contributions would enhance the clarity of the message and the credibility of the training.

**RECOMMENDATION 33** We recommend training for staff in the principles and procedural arrangements for the handling of complaints.

We have prepared considered comments on the Complaints Procedure in its present form which are incorporated in the report in Appendix D. The specific recommendations are as follows:

**RECOMMENDATION 34** We recommend that explicit recognition be made of the Complaints Procedure as the central record of complaints and information to that effect incorporated in all relevant procedures of the authority.

**RECOMMENDATION 35** We recommend that where a complaint has been made by a child in care of Lothian Region, that the investigation of the matter should be conducted by Lothian. The Child Protection Procedures and Police investigations should be activated where appropriate.

**RECOMMENDATION 36** We recommend that boundaries of responsibility should be clarified in respect of children in multi-disciplinary settings. Reference is made to APPENDIX B and APPENDIX C of this report.

(J) **OTHER RELEVANT PROVISIONS**

(I) **THE REGISTRATION AND INSPECTION UNIT**

At the time of this report the Registration and Inspection Unit of the Social Work Department was already undertaking registration of residential units for children provided by other bodies. The unit was about to begin inspection of the authority's own residential units.

Several aspects of registration and inspection appear to us to have the potential to make a contribution to effective handling of complaints from children, these include:—

- a. The extensive document “Standards: Residential Child Care” was, we understand, developed collaboratively by the Planning and Co-ordination Section, Operations Section, and Registration and Inspection Unit of the Social Work Department. We have commented elsewhere in this report that people to whom we spoke found the document very helpful in training and management. It appears to us that it lays a good foundation for the analysis and development of good child care practice.
- b. Inspection of units should identify and correct unsatisfactory practice affecting a whole unit and so promote high quality care, including good handling of complaints.

**Complaints:** In our discussion with the Head of the Registration and Inspection Unit, we heard that the work the unit had already undertaken had caused the unit to seek good links with the Client Services and Complaints Officer and the Regional Child Abuse Co-ordinator, so that information could be shared and responses co-ordinated. We have noted in the section in this report about the Complaints Procedure, that we endorse the present view of the Director that the investigation of complaints by children in the care of Lothian and placed in other units, should be taken forward primarily by the Complaints Procedure, Child Protection Procedures, and Police investigation, not by the Registration and Inspection Unit staff directly. We take the same view about complaints from children in Lothian units which may be articulated to Residential and Inspection Unit staff in the course of their work.

We understand that the Registration and Inspection Unit is making arrangements to communicate concerns which amount to possible allegations of abuse to the Regional Child Abuse Co-ordinator. It appears to us that that approach would be helpful.

The incidence of complaints may well indicate areas of concern about practice in an establishment which require the attention of the Registration and Inspection Unit. Just as we commend the principle of good communication by the Unit to the Client Services and Complaints Officer, so we commend similar reciprocal communication.

Both Registration and Inspection and Client Services and Complaints are relatively new parts of the Social Work Department's service. At the time of our report they were developing lines of communication and ways of working together. It is noted that the client services and complaints function in Lothian is located in the Director's office rather than in the Registration and Inspection Unit or its equivalent. We

understand this location manifests the importance attached by the Director to hearing and attending to complaints. One consequence of the separation of client services and complaints from registration and inspection is that more deliberate attention requires to be paid to the ways in which the two parts of the Department work together and share information than would be the case if the Services were located together when such collaboration would be likely to grow in an informal way.

**RECOMMENDATION 37** We recommend that the collaborative and consultative mechanisms between the Registration and Inspection Unit and Client Services and Complaints Officer, and others in the Department, should be extended and refined.

(II) **LOTHIAN CHILDREN AND FAMILY CHARTER**

Historically children had no rights or very few. Even recently, children in care, although they were young people for whom it was easy to express general sympathy, had the paternalistic parental role taken over and added to by the local authority. As an aside we would observe that, within the Children's Hearing system itself, though the Hearing might be charged with requiring to hear the child, it might be difficult for them to do so in the face of the views of the adult parent and adult social workers not least where because of the legislative and practice provisions the child would be likely to be unrepresented.

The general recognition of children's rights has been enhanced by the UN Convention. That convention is recognised by the Directorate and practitioners within the Social Work Department. The rights of young people as individuals and not "objects of concern" is recognised in the Cleveland and Orkney reports. The rights are recognised in the legislation relating to Complaints Procedure and in particular to the priority which is given by Lothian Region in regard to the operation of the Complaints Procedure.

The rights issue is also prominently recognised by Lothian Region in the establishment of the Children & Families Charter. In this regard one of us was particularly interested to ask the young people about their knowledge of the Charter and found that the majority of them had a pretty clear idea of its contents. Most of the young people were able to produce or confirm that they had membership cards. To be fair none of them seemed to think that the Charter meant very much for them but they said that they knew that if they were worried about something that there was "some body" that they could get in touch with.

(III) **"CHILDREN'S RIGHTS OFFICER"**

Lothian Region plans to appoint a person as Children's Rights Officer or as the current draft Job Description puts it "Young People's Information, Rights and Complaints Officer". Appointments of a

broadly similar kind have been made in a number of Local Authorities in England and Wales and in Scotland. We have had the opportunity to review the documents about this post and have met with the present Children's Rights Officer in Tayside Region.

We understand the job to have the following central tasks:

- a. The provision of general information about rights and responsibilities to all children in care.
- b. Heightening the profile of the children's rights' perspective in planning and service delivery within the Social Work Department.
- c. Advice and assistance to individual children in care who wish to use the Children's Rights Officer to assist them in making their concerns known and having their complaints addressed.

For the purposes of this report we have concentrated on the third of these tasks. From our discussions with young people, consultation with the Tayside postholder and general reading, we formed a view that to be effective in the last of these tasks, advice and assistance to individual children, the Rights Officer needs to be known and trusted by young people. Time and again young people told us that they would find it more difficult to contact a person whom they did not already know. Many said that knowing the person was essential before they would have the confidence to discuss and disclose what it was that was bothering them. We noted with interest the provision in Tayside of a separate telephone number and answer machine facility for the Children's Rights Officer to promote the identity of the Officer and the confidentiality of callers. That person's experience was that before he became effective the young people tested him out with particular reference to confidentiality.

We support the concept of a Children's Rights Officer who is available to become known to young people in care and to enable young people to articulate their concerns. We do however have concern, given the size and location of the group of children in residential care of Lothian Region (see Appendix B of this report for further details), to whom must be added the large number of children in foster care of various kinds, that the Children's Rights Officer will face a very difficult task in delivering this service in a meaningful way.

We assume that the postholder's function in regard to complaints would be an enabling one. This would include being receptive to pick up the complaint in the first place and then helping the young person to bring it to notice within the appropriate system or systems. The Children's Rights Officer would also stimulate awareness of the issues and discussion of the subject giving young people confidence to utilise formal procedures where necessary. "Complaints" might not always be



formal complaints for a Complaints Procedure. The Children's Rights Officer might for example be consulted by the children in a particular Unit about aspects of the quality of their care or by a particular resident about proposed changes in his or her care plan. We also note the function of the post to bring to the fore with both staff and Managers, the perspective of the rights and responsibilities of young people and thereby to empower young people in the arrangements which are made within the authority.

The postholder will require well developed links with the Client Services and Complaints Officer and the Who Cares Officer, amongst others, and reference is made to the sections of the report suggesting the publicity which requires to take place including leaflets and posters with telephone numbers.

Given the size of the task, it may be that aspects of the work of the Children's Rights Officer would require to be phased as the post is introduced. It may be appropriate to consider, for example, whether as a first priority the postholder should seek to become known to the young people placed by the authority outwith Lothian Region, who necessarily have more distant links back to Lothian than children placed within the authority, or whether the more important priority for the Children's Rights Officer is to concentrate on young people in the authority's own units and their rights, including the quality of care they receive.

It would be unhelpful if the Children's Rights Officer post were to come into being with an impossible remit since such an outcome would mean the service existed on paper only, was not effective, and could in an extreme situation bring the whole concept of a Children's Rights Officer into disrepute.

**RECOMMENDATION 38** We recommend early appointment to the post of "Children's Rights Officer".

**RECOMMENDATION 39** We recommend that, in the light of the large number of children in care, and the number and variety of their locations, the Department seek to establish priorities for the work of the Children's Rights Officer, and monitor the provision of the service.

**RECOMMENDATION 40** We recommend that when the Children's Rights Officer appointment is made, early publicity about the identity of and how to contact the Officer should be made available to children, and commend the provision of a separate telephone number and answering service on the Tayside model.

## CONCLUSION

The High Court trial which gave rise to our remit exemplified graphically and frighteningly how easy it can be for members of staff to abuse the trust of the Department and more particularly the children who may be in their care. The events of the trial and our subsequent enquiry similarly exemplify the complexity of the issues and the fact that no simplistic solutions are available.

In this case, some children were heard and some ineffective action was taken based on what they said (the inconclusive disciplinary proceedings); some children were heard but not listened to in respect that what they said was brushed aside as being of little consequence or credibility and nothing was done; some children were heard originally but when they (for whatever reason and with whatever relief for staff) subsequently withdrew what they said, that ended the matter; some children though anxious and upset did not speak – they could not be “heard”. No-one picked up the unarticulated concerns.

In attempting to see whether potential for such four areas of concern might still be present today, we were provided with some doom-laden generalities – “it was an event waiting to happen”, “nothing has changed”, “it could happen again”. The Director of Social Work suggests that since the time of the incidents which gave rise to the trial the whole culture of understanding of such issues is now so markedly different that such a situation would be less likely to occur today. Such a suggestion might seem over-optimistic given that the date of the last offence in the High Court indictment was January 1991, a very short time ago.

Quite apart from “cultural” changes the Director of Social Work points to a number of practical developments which have taken place which makes it less likely that the situations which arose in regard to the trial would recur today.

While being wary of this report being seen as a “whitewash” (the term used by one of our respondents), our general view is that much has changed and that the incidents which gave rise to the High Court trial would be much more likely now to be dealt with more positively. Our basic reason for reaching that conclusion is that children are now much more likely to be heard and what they say acted upon constructively.

We have acknowledged that the Director and in the main the members of his Department, do not see the requirements of the Complaints Procedure to be a burden but rather welcome the principles behind the Procedures as being an aid to good child care practice. We have been encouraged that in the welter of responsibilities which fall on the Department and the difficulties and tensions which have inevitably arisen from the major restructure of the department, that there is a widespread welcome towards the possibility of the status of residential care as a professional task. We believe that the new department structure gives a basis which provides a very real **POTENTIAL** for improved standards in residential child care which will make it less likely for the events which gave rise to our remit to be repeated.

As reflected in the report, we write against a background of a number of Reports which have revealed extensive and persistent abuse of children in the care of Local Authorities in the United Kingdom. A common feature of these Reports is that their recommendations are subsequently found not to have been implemented. The content of the Reports indicates the complexities involved and the difficulties which Lothian Social Work Department faces in attempting to ensure that there will be no recurrence.

That said, we have seen fit to make a number of recommendations which we have included throughout the report and summarised at the end of this Section which we hope might assist the Department towards their own stated aims and further develop the progress which they have made. Of these we would draw particular attention to:

1. The need for the department to adopt a consistent and thorough recruitment practice for residential care staff.
2. The need for a consistent departmental policy and practice relating to record-keeping for clients, units and staff.
3. A recognition of the need for the Department to maintain sensitive information on staff which at present they are not permitted to retain.
4. The need for development of training at all levels including induction training. That training should incorporate specific training in regard to gender and sexuality issues, child protection and the Complaints Procedure.
5. The need to develop a consistent, sophisticated practice relating to supervision of staff.
6. The need to continue the present readiness within the Department to hear children and to recognise their rights as individuals including their right to take advantage of the Complaints Procedure.
7. The need for a consistent and sensitive procedure for the investigation of complaints and of appropriate individual support for any child through the complaints process.
8. Recognition that within the large Department there are countless examples of good practice and the need to draw on this wealth of experience to promote imaginative and good practice across the Region.

In making these recommendations we are conscious of how easy it is for outsiders who carry no ongoing responsibility to advise those who do have these responsibilities as to how they should go about their task. We are equally conscious that whereas we understand many of the changes which we have recommended are in keeping with the aims of managers and practitioners that in the light of their many responsibilities and the difficulties placed on them by lack of what they (and we) perceive to be inadequate resources, they may experience difficulty in ensuring that their intentions are given the priority and attention which they demand.

The High Court trial has provided an impetus for the Department to examine practice and management issues. It is important that that impetus should not be lost and it is with that in mind that we have proposed that through the medium of the Annual Report of the Client Services and Complaints Officer (Recommendation 29) an annual audit be taken of what progress has been made in relation to the specific position of complaints by children in residential care. It would be a matter for the Director to consider whether or not to report such matters annually to the Social Work Committee.

Our cautious note of optimism for the future draws strength from two further sources. In the first place we note that nobody in the department is adopting a complacent position that now that matters have been recognised there will be no recurrence. We take that as an indication of the Department's commitment to their doing all they can to try to prevent recurrence.

Equally, if not more relevantly, we derived confidence from the young people and staff whom we met during our visit. Many of the children were particularly clear about their right to complain and of how to do so. They had and have a great deal to say about complaints and the present climate and new arrangements within the Department as exemplified by the proposal to appoint a Children's Rights Officer encourage us to believe that children are now much more likely to be heard.

The popular press and professional publications remind us of how difficult many of these young people can be and there is no doubt that they present considerable personal and professional difficulties. As much as their awareness of their rights we would wish to conclude this report by recording how much we enjoyed our visits.

While we might have anticipated and did receive courteous reception from staff, we were delighted by the way in which the young people themselves made us most welcome. They spoke freely to us. We could not but be impressed by the easy, confident relationship which they enjoyed with staff. No doubt for many of them we called on a good day and our visit might have been sufficiently out of the ordinary to create some kind of interest for them. We are well aware that at other times a different picture might have been presented. Nonetheless the Units were not selected for us and we saw some 35 children. The confidence which they displayed and the atmosphere which obtained during our visits were such as to give us confidence about the manner in which difficulties would be dealt with when they arose, helped us recognise the quality of the care which they were receiving, and enabled us to enjoy the time spent in their company. In recognising the way in which the residents presented we are very mindful of the contribution which the staff have made in that regard.

## 4 LIST OF RECOMMENDATIONS

**RECOMMENDATION 1** We recommend that the current impetus provided by the Warner Report and the Lothian High Court trial should not be lost and that direct reference to such matters in future training would help to make the issue a relevant live one rather than a theoretical possibility.

**RECOMMENDATION 2** We recommend that the Department consider the need for consistency and thoroughness in selection procedures for staff in residential work for children, and in the light of that requirement develop methods of recruitment. It may be that such requirements can best be met by a combination of expertise from central and district staff. At the very least centralised personnel section and managers should oversee closely the recruitment policy and process to endeavour to ensure these standards of consistency and thoroughness.

**RECOMMENDATION 3** We recommend that the Department continue and extend the practice of including in interviews issues such as care and control, sexuality and complaints from children.

**RECOMMENDATION 4** We recommend that efforts should be made to increase the numbers of permanent as opposed to temporary staff.

**RECOMMENDATION 5** We therefore recommend that despite the current Regional Council Policy, the Department attempt to establish a probationary period for residential staff.

**RECOMMENDATION 6** We recommend that in light of the foregoing paragraphs the Department consider creating an innovative extended recruitment programme incorporating training and assessment for residential workers with children.

**RECOMMENDATION 7** We recommend the establishment of a consistent Regional, District and Unit policy for supervision, and that Service Provision Managers, in conjunction with their managers and the training section establish a training programme for those who will have the responsibility of supervising. Further, we recommend that the Regional Policy on supervision be developed and implemented on a shared basis drawing on the experience of good and bad practice.

**RECOMMENDATION 8** We recommend that additional training for staff in issues such as direct care of children including physical contact with them, sexuality, child abuse and the care of children who have been abused, should be made available as a priority.

**RECOMMENDATION 9** We recommend that consideration should be given to the induction programme for new members of residential care staff. We recommend that a programme of training should take place early in a staff member's career and that consideration should be given to some training before staff join units at all.

**RECOMMENDATION 10** As a corollary to the training programme we recommend that all units ensure that the relevant Procedures and other documentation are available within the Unit and that all grades of staff should be expected to know the contents and incorporate them in practice.

**RECOMMENDATION 11** We further recommend that consideration should be given to the need for some of this training to be undertaken by whole staff teams.

**RECOMMENDATION 12** We recommend that discussion and sharing of developments in practice across the divisions and the central units be encouraged, and that consideration be given to putting arrangements in place to enable such discussion and sharing.

**RECOMMENDATION 13** We recommend that the District Managers make a priority of ensuring allocation of cases where young people are in residence; that fieldworkers as part of their responsibilities make it clear to young people who are about to be placed in care or those who are in care that they are available and would wish to hear about any issue of concern that may arise for the young person as a result of their being in care; that fieldworkers recognise that up till now in many instances (despite their protestations about "good relationships") that they have not provided an effective outlet for such matters and should use that recognition to work out how best they can provide for that contingency in the future.

**RECOMMENDATION 14** We recommend that the Director of Social Work enter into negotiations with the Personnel Manager and Regional Solicitor to adopt a specific Policy for retention of information on current and former members of staff.

**RECOMMENDATION 15** We recommend further attention to the preparation and training of staff in investigation.

**RECOMMENDATION 16** We recommend consideration be given to preparing notes of guidance for staff involved in investigation.

**RECOMMENDATION 17** We recommend that at an early stage the Department should identify who is to carry out the investigative responsibility within the Department, who is to monitor the enquiry and what arrangements should be made to enable these matters to be addressed consistently.

**RECOMMENDATION 18** We recommend that serious consideration be given in any case where abuse is alleged, to the need to demonstrate the independence of an investigation. That consideration should include the possibility of locating the enquiry outwith the District, or including in the investigation team a member of staff from outwith the District.

**RECOMMENDATION 19** We recommend that regional training for staff conducting disciplinary enquiries should be taken up by all staff conducting such enquiries.

**RECOMMENDATION 20** We recommend that in any disciplinary enquiry the Investigating Officer should consult, at an early stage, with the Senior Employee Relations Officer and continue regular consultation thereafter.

**RECOMMENDATION 21** We recommend that the potential of the Police to assist the investigation process and those involved therein be recognised and utilised.

**RECOMMENDATION 22** We further recommend that discussions take place between the Social Work Department and the Police service to put in place detailed working arrangements to facilitate future co-operation along the lines described in the paragraphs above.

**RECOMMENDATION 23** We recommend that the Authority, in co-ordinating investigations of this kind, should ensure that the young person is kept informed of what is happening and of the eventual outcome of the matter. This consideration should also extend to staff who raise complaints on behalf of young people or who enable young people to have their complaints heard.

**RECOMMENDATION 24** We recommend that in future when any allegation of this kind has been made that an appropriate Case Conference be called.

**RECOMMENDATION 25** We further recommend that where the Child Protection Guidelines were being invoked that the Case Conference be convened by the Regional Co-ordinator of Child Protection.

**RECOMMENDATION 26** We recommend that when a child has made an allegation of abuse, a decision be taken to identify a key individual who would have paramount responsibility to provide appropriate support to the individual child.

**RECOMMENDATION 27** When judicial proceedings arise from an allegation, we recommend that the key individual providing support to the child should provide appropriate support before, during and after the judicial proceedings.



**RECOMMENDATION 28** We recommend clarification of which matters or issues raised by young people require to be processed as formal complaints.

**RECOMMENDATION 29** We recommend that information should be made available to young people about the Complaints Procedure and that this information must include the identity of persons to whom complaints may be made and the telephone numbers of those people.

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**RECOMMENDATION 36** We recommend that boundaries of responsibility should be clarified in respect of children in multi-disciplinary settings. Reference is made to APPENDIX B and APPENDIX C of this report.

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**RECOMMENDATION 38** We recommend early appointment to the post of "Children's Rights Officer".

**RECOMMENDATION 39** We recommend that, in the light of the large number of children in care, and the number and variety of their locations, the Department seek to establish priorities for the work of the Children's Rights Officer, and monitor the provision of the service.

**RECOMMENDATION 40** We recommend that when the Children's Rights Officer appointment is made, early publicity about the identity of and how to contact the Officer should be made available to children, and commend the provision of a separate telephone number and answering service on the Tayside model.

# APPENDIX A

## LIST OF INDIVIDUALS INTERVIEWED IN RESPECT OF THE ENQUIRY

### MEMBERS OF THE SOCIAL WORK DEPARTMENT

1. The Director of Social Work
2. The Senior Depute Director of Social Work
3. The Depute Director (Operations)
4. The Client Services and Complaints Officer
5. One District Manager
6. Emergency Duty Team Co-ordinator
7. Seven Service Provision Managers (Children & Families) (a number of these had previous experience in the former Residential and Day Care Section with responsibilities varying from Acting Principal Officer to Assistant Principal Officer)
8. The Principal Officer (Training)
9. The Assistant Director (Human Resources)
10. The Personnel Manager
11. Senior Employee Relations Officer
12. Planning & Co-ordination Manager (Children & Young People)
13. Principal Officer (Children & Young People), Planning & Co-ordination
14. Regional Co-ordinator (Child Protection)
15. Principal Officer (Operations – Children & Young People)
16. Staff and Residents of Seven Residential Units
17. Two Other Unit Managers (each of whom had had responsibilities for children involved as victims)
18. One former Assistant Principal Officer (Residential and Day Care) who had investigated the events giving rise to the trial.
19. A member of staff allocated the responsibilities for reporting to the Director on the trial.
20. Registration and Inspection Officer (in that capacity and in his former capacity as Assistant Director (Residential and Day Care).

### INDIVIDUALS OUTWITH THE DEPARTMENT

21. The wife of the accused (at her request and at the request of her Solicitor at a meeting at which he was present).
22. One young person who had been a witness in the trial.
23. Who Cares Development Officer
24. Principal Officer, Solicitor's Department, Lothian Regional Council
25. Personnel Manager and colleague, Lothian Regional Council
26. Superintendent, CID with responsibility for Woman and Child Unit.
27. Key CID Police Officer in regard to the trial with her Sergeant.
28. Children's Rights Officer, Dundee

## APPENDIX B

### THE CHILDREN IN CARE AND PLACED IN RESIDENTIAL FACILITIES BY LOTHIAN REGION

As part of our work for the report we attempted to quantify the group of children in care and to look in general terms at where they were placed.

In a typical snapshot week we are advised the following numbers of children were in care of Lothian Region.

In Lothian Region facilities	
Young People's Centres	115
St Joseph's & Wellington Schools	68 residential pupils (38 day pupils)
Howdenhall Secure Unit	5
In Facilities within Lothian Region managed by other bodies	
Moorehouse School (Bathgate)	25 residential pupils (3 day pupils)
Other Facilities	24 residents
Outwith Lothian Region	
Residential Schools	67
Secure Units	20

#### SUMMARY

In units directly managed by Lothian	188
	+ 38 day pupils
With the Region but not managed by the Region	49
	+ 3 day pupils
Outwith the geographic boundaries of Lothian Region	87

#### NOTES:

1. A significant number of children are placed outwith the Region's own units – a total of 139 children and young people were placed in units not directly managed by Lothian, of whom 87 were physically outwith the boundaries of the Region.
2. It may be that there are other small groups of children which should be considered – for example there may be children in hospital facilities or children in specialist facilities for children with special needs of various kinds where the placements may be jointly between social work and another agency or where the child may be receiving social work care as well as other care.
3. It should also be noted for the sake of completeness that 20 of the young people in residential schools also had home bases in the Lothian units and that that 20 has not been counted in the 115 shown in the table above.

## APPENDIX C

### INVESTIGATION: HYPOTHETICAL EXAMPLES (SEE PAGE 40)

#### EXAMPLE A

A 14-year old boy is in a secure unit. He is being bullied by two other residents. He has told the Head of the Unit about the bullying. The Head has arranged for him to change rooms to avoid being so much in the company of the bullies, but the boy thinks that the Head is also very critical of him for not standing up for himself more. After a lull of a week or two, the boy is again being verbally taunted, and physically assaulted by the others and threatened with a "doing" if he does not bring tobacco back to the Unit after his next home leave. The boy goes home, tells his mother what is happening. She contacts the boy's social worker with the boy, to complain about this matter and makes it clear that the family do not wish the boy to return to the Unit until the matter has been cleared up.

#### EXAMPLE B

A 13-year old girl tells a female Care Officer in her Unit that a male senior member of staff came into her room the previous evening when she was dressed in her nightie and was brushing her hair. The male member of staff complimented her on her shiny hair, put his arm across her shoulders and gave her a "sort of hug". The girl is upset. She wants the behaviour stopped but does not want a big fuss made. She knows about the Child Protection Procedures as she is in care because of abuse at home.

#### QUESTIONS ARISING

1. How is the immediate position for the young person to be dealt with, and by whom?
2. In what way would the management of the situation differ if:
  - a. the Unit is in Lothian and managed by Lothian;
  - b. the Unit is situated in Lothian Region but managed by another body;
  - c. the Unit is located outwith Lothian Region and managed either by another Local Authority or by a voluntary body?
3. In any of these situations what would the role of the following Procedures be?

Care management, eg Child in Care Reviews, Children's Hearing Review; The Child Protection Procedures; enquiries by the Police; The Complaints Procedure of Lothian Region; Staff Discipline enquiries; enquiries by the Registration and Inspection Unit of Lothian or of another Authority?
4. Who carries responsibility for identifying the route by which matters should be taken forward and implementing the necessary arrangements?

## APPENDIX D

### DETAILED COMMENTS ON THE COMPLAINTS PROCEDURE

The Complaints Procedure forms a central part of our remit. We have made the following detailed comments on the Procedure in its December 1992 form. We have included these in an Appendix, firstly because the Complaints Procedure is subject to regular revision and changes may render these comments out of date very quickly; and secondly, to enable detailed quotation and discussion to be made without interrupting the argument of the report as a whole.

#### **"Informal versus Formal Complaints – Responsiveness to Clients."**

##### **Page 5 paragraph 7**

"Responsiveness to the clients with whom we are working is part of our work, and frontline staff have always sought to explain carefully to clients the Department's responsibilities and criteria for decisions and to take account of their views and wishes. The Council's Open Access policy reinforces an open approach.

The nature of our work does mean that from time to time clients will be unhappy with our decisions or the way we are working with them.

It obviously makes sense to check out clients' views frequently and to try to resolve any dispute or misunderstanding when it arises, with the assistance of first-line Managers if appropriate. The Social Work (Representations Procedure)(Scotland) Directions 1990 preserve the right of both clients and officers to deal informally with informal representations.

Most disputes and expressions of concern by service users will be dealt with to the satisfaction of the client at or below Team and Unit Manager level without recourse to the Complaints Procedure.

However, if clients remain unsatisfied they do have a right to use the Complaints Procedure and staff have an obligation to help them to do so.

All allegations of abuse, neglect or improper conduct by staff must be reported through the Complaints Procedure. Such allegations will always be investigated thoroughly by a senior member of staff outwith the unit concerned. Where the allegation constitutes prima facie evidence of a criminal offence the Director/Senior Depute will ensure the complaint is referred to the Police for criminal investigation."

Reference is made to the opening paragraph of the Section of this report on Complaints Procedure – "Identification of a Complaint".

The tone of this section suggests that the person making the complaint is a fully capable adult. There are particular difficulties for young people in articulating complaints which we have rehearsed extensively elsewhere in this report.

We note the terms of the final paragraph "All allegations of abuse, neglect or improper conduct by staff must be reported through the Complaints Procedure."

Where complaints of this nature from young people in care are concerned, most investigations into allegations of this kind would be taken forward under the Child Protection Procedures, the Disciplinary Procedures of the Local Authority, and the Police.

We do, however, see two particular advantages of having all such matters referred into the Complaints Procedure:

- a. that the Complaints Procedure is the only place where all such matters would be recorded centrally; and
- b. it gives a certain and early oversight by the Director or the Senior Depute of any matter of this kind.

If this recording mechanism is a function of the Complaints Procedure then that function may need to be articulated more clearly within the Complaints Procedure. There may also require to be specific instructions, for example, in the Discipline Procedure, Registration and Inspection Procedures and Child Protection Procedures, about this matter, or indeed perhaps there requires to be a cross-reference in all of these Procedures to the importance of allegations of this kind being referred to, and recorded in, the Complaints Procedure.

**RECOMMENDATION 34** We recommend that explicit recognition be made of the Complaints Procedure as the central record of complaints and information to that effect incorporated in all relevant procedures of the authority.

**“Private and Voluntary Residential Homes”**  
**Paragraph 6 on Page 7**

Registered private and voluntary residential homes must have a Complaints Procedure approved by the Registration and Inspection Unit and make it available to residents. In addition such information as the name, address and telephone number of the Inspector allocated to the home must also be made available. Homes will display prominently their Procedures and details of the allocated Inspector, and in all cases new residents should receive a personal copy of this information.

Private and voluntary homes are required to send details of complaints received to the Registration and Inspection Unit. The Head of Inspection may investigate complaints directly, but if the Head of Inspection is satisfied that the organisation’s management have dealt with the complaint or should do so, they will inform them accordingly. However in all cases of alleged abuse or neglect, the Registration and Inspection Unit should investigate the complaint.

The responsibility for ensuring that approved procedures are in operation will rest with the Registration and Inspection Unit. Information on their procedure will be included in the annual Inspection report.”

We understand that since the Complaints Procedure was prepared, the Authority is already reviewing the position of children who are in the care of Lothian and placed in a voluntary establishment. We would concur with the view that such a child is in a different position from that of other clients since the Authority has a continuing over-arching responsibility to the child in its care.

**RECOMMENDATION 35** We recommend that where a complaint has been made by a child in care of Lothian Region, that the investigation of the matter should be conducted by Lothian. The Child Protection Procedures and Police investigations should be activated where appropriate.

In such a case Staff Disciplinary Procedures may well require to be operated by another organisation.

We see the responsibility for investigating complaints from children to be that of the Client Services and Complaints Officer and the other Procedures we have identified and not the primary responsibility of the Registration and Inspection Unit. We suggest in the section of this report dealing with the Registration and Inspection Unit that allegations coming to the notice of the Inspectorate, should be referred into the Complaints Procedure and other Procedures, presumably via the District Manager and, in respect of Child Protection, to the Regional Child Protection Co-ordinator.

Reference should be made to the section of the report on Registration and Inspection. Emphasis is laid on the importance of good communication and cross-referencing of matters between the Registration and Inspection Unit and the Client Services and Complaints Officer.

**“Inter-Disciplinary Assessments/Multi-Disciplinary Settings:  
Page 7 Paragraph 8;**

“Where a complaint relates to a decision reached jointly with another agency the Complaints Officer will inform the agency to ascertain their view and prepare a recommendation for the Director/Senior Depute’s consideration which include arrangements for collaboration. The complaint will as far as possible be handled in accordance with this procedure.”

The paragraph as presently drafted appears only to envisage the situation where a complaint is being made about a decision reached jointly with another agency. We suggest that the problem may be much wider in scope. Ongoing inter-disciplinary work occurs for example where social workers are operating in medical settings or social work and education are co-operating to provide services – residential or on a day basis. Complaints could be about abuse, poor service or about particular happenings and events.

**RECOMMENDATION 36** We recommend that boundaries of responsibility should be clarified in respect of children in multi-disciplinary settings. Reference is made to APPENDIX B and APPENDIX C of this report.