PE1836/C
Scottish Public Services Ombudsman submission of 14 January 2021

Thank you to the Committee for giving the me an opportunity to submit the SPSO's views on this petition.

The petitioner has outlined a problem; concerns about difficulties in challenging social work reports, particularly where a child is in care (a looked-after child), and proposed a solution; providing the Care Inspectorate with the power to investigate individual complaints.

Having reflected carefully on the petition, the evidence given and the comments of the committee on 16 December 2020, I am responding by looking at those two points separately.

I will first comment on the evidence we hold about the quality of social work provision and then on whether the proposed solution would be the best approach to resolving the concerns raised by the petitioner.

SPSO experience

As the final stage for complaints about local authorities, social work is under my jurisdiction. The jurisdiction is wide and enables me to investigate and make findings and recommendations about service delivery of processes and procedures, **and** the merits of professional decisions made by social workers and others exercising social work functions.

The powers relating to being able to challenge professional decisions were conferred on the Ombudsman following concerns being raised about the previous complaints scheme (Complaints Review Committees) which required complainers to attend an internal complaints review committee hearing. This resulted in the Scottish Government abolishing the previous statutory scheme and we were given additional powers from 1 April 2017.

Volume and key figures[1]

Since the 2017 change we have seen a rise in the number of substantive complaints made to us. This is what we would have expected given the change simplified the process and reflects what we have seen in other areas when complaints processes are made easier for people to access and complete.

A significant change has been the reduction in the number of premature complaints. Premature complaints are complaints made to us before they have completed the local, internal process. We use this as an indicator of people's experience in navigating and accessing local procedures. Put simply, a lower proportion of premature complaints is a general indicator that local complaint processes are being accessed and completed timeously.

[1] These figures are for all social work but the trends are consistent across all subjects.

Social work historically had one of the highest premature rates and it is encouraging that the service is now in line with the average for local authority complaints. This suggests that service users are able to use and access complaints procedures, and that organisations are responding to them (although we recognise there is always scope for all of us to develop and refine our approach).

Another indicator of the benefits of the change is the number of complaints we receive that we can now investigate. This has significantly increased because we can look at the merits of the decisions. This means we have been able to look closely at more complaints, resulting in a significant increase in the number of decisions where we have upheld and supported the position of the complainer.

The uphold rate is now similar to health where we also have this extended jurisdiction (to look at both process and merits).

	2016/2017	2017/2018	2018/2019	2019/2020
Volume of SW complaints received	**219**	**340**	**361**	**329**
Premature rate	**53%**	**25%**	**22%**	**20%**

Number investigated	**9**	**21**	**51**	**54**
Uphold rate	**37%**	**66%**	**66%**	**65%**

Our findings

We publish anonymised summaries or full reports of cases investigated, enabling us to share the critical detail of our findings and recommendations. Relevant themes from our published casework across child protection include: failure to listen to and take the views of children into account[2]; and failure to gather all relevant evidence and provide a clear rationale for key child protection decisions[3]. Our casework, while not definitive on the concerns expressed in the petition provides some support for concerns about the quality of social work decision-making relating to children.

While our work can provide some general evidence, it is important to note that the petition specifically references children's hearings and looked-after children. Anything put to a children's hearing can be challenged at that hearing and decisions of children's hearings

[2] https://www.spso.org.uk/decision-reports/2020/november/decision-report-201900885-201900885; and
[3] https://www.spso.org.uk/decision-reports/2020/october/decision-report-201806908-201806908 and; https://www.spso.org.uk/decision-reports/2020/august/decision-report-201903373-201903373; and https://www.spso.org.uk/decision-reports/2019/october/decision-report-201804660-201804660

can be further appealed to a Sheriff. My legislation says that I should not normally consider matters that could be appealed to a court and SPSO is not able to question the judgement of a children's hearing, this means our role in relation to reports put to children's hearings is more limited and so we have less direct evidence. **It is important to note** that this would remain the case whatever organisation was involved in complaints as it is not appropriate for a complaints handling process to intervene in a legal process.

I note the concerns in the petition that the process for legal challenges is not accessible and return to that point in the comments below.

While we receive complaints on behalf of children who are or have been taken into care, these are few in number and complaints tend to come from families where the parents (or legal guardians) are better able to navigate the system or have good advocacy support. This means, while we can extrapolate from our general evidence around child protection, there is less direct evidence about the experience of looked-after children in the complaints system.

The proposed solution

While SPSO casework contains some indications that, suggest that at times, social work decision-making is not of the required standard, I do not consider it to be sufficient to warrant supporting the proposed solution. As the evidence from the Scottish Government shows, this is already a complex area in terms of the numbers of agencies involved and their roles. Introducing further complexity into the system is unlikely to produce benefits and runs counter to developments over many years to simplify the complaints processes across Scotland. It also would have limited impact on the specific situation referenced by the petitioner as the decisions of children's hearings would remain subject to court appeal and outside the remit of a complaints process.

I refer back also to my earlier point about the change in complaint volumes when the current, simpler complaint process was introduced. What that suggests to me is that making the system and landscape more complex runs the risk of restricting access and deterring people from using, not encouraging them.

This does not mean there are no improvement changes that could be made that would improve the complainer's journey through the complaints process from local level to regulation at a national level. Indeed, one of the requirements of the model complaints handling process is a focus on learning and improvement. We monitor complaints handling performance and through our Support and Intervention Policy actively pursue improvement

where need is identified. We have also updated the model complaint handling process in light of learning and experience recently.

In addition to the focus on making the current systems more effective, there are national initiatives which should impact positively on complaints from or concerning children. One of the welcome outcomes of the proposed incorporation of the UN Charter for Children's Right is recognition of the requirement for child-friendly and, I would argue, child-focussed complaints processes. As a stakeholder with a significant interest in this area, I will be participating actively in the development of the incorporation, for example I will be participating in a webinar on this in February, chaired by the Children and Young Person's Commissioner for Scotland. I am keen to see Scotland lead in this area.

Improvements to make complaints more accessible to looked-after children about their care do not require legislative reform. But it is the case that looked-after children will remain a vulnerable group who will be reluctant to complain. The Scottish Children and Young Person's Commissioner will, if the current bill is passed, take on the power to initiate court action when no individual child is able to do so.

Many Ombudsmen have a parallel power which allows them to take complaints even when no one has complained and this is a matter which I have raised with both this Parliament and the Scottish Government and I intend to pursue the need for reform of our legislation within the next parliament. This is a significant omission in my powers as it means I cannot investigate matters I identify which are in the public interest, even if they are significant, if I don't receive a complaint about them. This means that there are likely to be issues that impact on vulnerable individuals and groups that go unaddressed simply because they don't complain.

These are general improvements and despite the comments made about the inability of the complaints process to intervene in a legal process, I would suggest there are two areas that could help support and improve the positions for families and children.

- improved advocacy support for children and families and
- the ability to more constructively share information amongst key agencies.

A key factor when we identify good practice, is access to good advocacy support for children and families. There have already been positive recent developments with the recent legislation (Children (Scotland) Act 2020) that focused on listening to children, including younger children and the launch of the hearings advocacy website. For individual children and their families, access to good, supportive information and advocacy at key

points in their involvement with social work may well be the most effective route to preventing problems and resolving issues in the hearings and courts system.

It is also important that we take a systems approach to early detection of problems and to prevent problems recurring. We publish our findings and recommendations to encourage others learn from individual complaints. We are also a member of the Sharing Intelligence in Health and Care Group which brings together agencies on a monthly basis to share information about trends and themes. To date this has focussed on the NHS but we would argue a similar model would be of benefit for social work and would help us collectively drive systemic change.

In closing, while I consider there are improvements that could be made, these do not lie in increasing the complexity of the accountability structure but improving and adequately resourcing existing systems to ensure timely, good quality support is available for children and families and that agencies collectively improve our approach to information sharing to support systemic improvements.