Glasgow City Council

Education and Social Work PDS Committee

19 June 2007

Report by Directors of Social Work and Education Services

Contact: David Comley Ext: 78853

KERELAW INVESTIGATION

Purpose of Report:

This report informs Committee of the outcomes of the Kerelaw Investigation and identifies action required to address the issues identified during the course of the investigation.

Recommendations:

Committee is requested to:

a) note this report;
b) note the action plan; and
c) refer to the Executive Committee concerns around the limitations of national safeguarding processes and the development of a nationally agreed contract with residential schools.

Ward No(s): : Click Here to enter text

Citywide: ☐

Local member(s) advised: Yes ☐ No ☐

consulted: Yes ☐ No ☐

1. Purpose of Report

1.1 This report informs Committee of the outcomes of the Kerelaw Investigation, the action taken by Social Work Services and identifies action required to address the issues identified during the course of the investigation.

2. Background

2.1 Kerelaw Open School and Secure Unit were situated in Stevenson, Ayrshire, and from 1996 were managed by Glasgow City Council. The Open School could accommodate 50 young people and the Secure Unit accommodated 24 young people. Local authorities from all over Scotland placed young people but there were always a significant proportion of children placed by Glasgow.

2.2 Kerelaw School and Secure Unit provided care and education for a range of young people, primarily young men, with significant, complex and varied needs. In general terms the population would be older young people aged 13+, most with a history of being looked after by the local authority either in foster care or residential units, involved in offending behaviour, and with significantly disrupted education. These young people often presented with challenging behaviour and would have required skilled interventions to address their behaviour and meet their needs.

2.3 Latterly the staffing establishment consisted of 165 staff, with 30 of those in management positions. This does not include a further complement of catering and cleaning staff.

2.4 In June 2004 arrangements were put in place by the Directors of Social Work and Education Services to investigate wide-ranging complaints and concerns from residents, current employees and former staff and by August 2004 a Joint Investigation Team was established. These complaints in their entirety spanned 25 years. Employees past and present, residents, parents and associated professionals were interviewed and amassed records scrutinised during a two-year investigation.

2.5 Essentially this two year investigation concluded that there was a long-standing failure within the school, which continued to early 2004, to provide safe, effective and appropriate care and education for young people in Kerelaw School and Secure Unit, with some young people subject to sexual, physical and emotional abuse by certain members of staff. This reports sets out the detail of the investigation, the action taken by the Council to date and an action plan to continue to address the issues identified during the course of the investigation.

2.6 Abuse of children in public care has been the subject of considerable interest nationally over the last 15 years, and events at Kerelaw and our response can be set against a number of reports, reviews and public inquiries.

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3. Investigation Activity

3.1 The focus of the investigation has been individuals subject to allegations who were employed by the City Council in Kerelaw School or Secure Unit, and remained in our employment at the time of the allegations and investigations. Former employees who were the subject of allegations were referred by the Investigation Team to the Police, the Scottish Executive and the Scottish Social Services Council. The investigation team did not carry out any investigations into external management of the School, as this had been the subject of a separate report to the Chief Executive in April 2005, the conclusions of which were reported to the Council's Policy and Resources Committee on 12th April 2005.

3.2 The Joint Investigation Team carried out 38 fact-finding investigations. 23 disciplinary hearings were held which resulted in 14 dismissals, 7 other disciplinary outcomes (final/written warnings) and 12 investigations leading to management action, re-training or no further action. All individuals dismissed, with one exception, have appealed that decision. The Appeals Sub-Committee upheld 1 appeal with a reduced penalty.

3.3 These investigations considered a large numbers of complaints including assault, verbal abuse, inappropriate sexual behaviour, excessive restraint, wide ranging mismanagement and misconduct issues.

3.4 In addition to the management action taken within the Council, 20 individuals have been reported to the Procurator Fiscal. Of these, 2 individuals have been convicted of sexual and physical offences and are imprisoned. Allegations against 2 individuals have been dropped. Of the remainder, 5 individuals have been reported to the PF for offences of a sexual nature, and the remaining 10 individuals on allegations of multiple assault. One individual is now deceased.

4. Key Issues From Investigation

4.1 Disciplinary action has been taken for all those individuals identified and employed by the council found to be responsible for abuse and mismanagement within the school and secure unit. In addition to this action we have addressed the immediate issues arising from the investigation, and have formulated an action plan based on our analysis of the failures at Kerelaw to ensure that lessons are learned from this investigation.

4.2 The conclusion of our investigations was that a significant number of staff, many in management positions, were involved in the physical abuse of young people. This included physical assaults, excessive use of restraint outwith policy, inappropriate restraint and a range of physically abusive and intimidating behaviour characterised by staff as "horseplay".

4.3 The investigation concluded, as have court proceedings, that young people had been sexually abused by certain staff members. Moreover, the culture at Kerelaw was characterised by a lack of appropriate professional boundaries between staff and young people. This included inappropriate relationships, a chronic lack of privacy for young people, young people having knowledge of staffs' personal relationships and an absence of boundaries regarding staff use of inappropriate language and dress code.

4.4 The investigation also concluded there was a culture of physical and emotional abuse, where staff members used their authority to deny basic rights to young people.

4.5 In addition to specific instances of abuse the investigation has concluded that there were systemic failures which allowed a dysfunctional, insular and staff centred culture to develop in Kerelaw. The investigation shows that there was a significant core of staff, around 40 individuals, directly involved in abuse of young people. However, a far larger number of staff had knowledge and information about abuse and potential abuse, and were unable or unwilling to address this abuse, contributing to the development of the dysfunction within Kerelaw thereby failing to fulfil their duty of care.

4.6 The investigation also found that children, over the years, repeatedly made the same types of comments, complaints and allegations about their general treatment at Kerelaw, about specific abusive behaviours by specific members of staff and about other matters relating to staff conduct. Despite this, internal systems for management of the school, external management of the school, investigation of complaints, effective detection of patterns of staff misconduct, child protection and the provision of basic care and education all failed.

4.7 In the course of our investigation to date it is also clear that, throughout Kerelaw's history, there have been deficiencies in the quantity, quality, visibility and assertiveness of external management with regard to expected care and education standards in the school.

4.8 In addition to the internal and external management, a range of individuals and bodies had contact with the young people at Kerelaw. Prior to 2002, when the Care Commission was established, the school was inspected by the Social Work Services Inspectorate and by north Ayrshire Council. The Care Commission took responsibility for the regulation of the school in April 2002. Following concerns raised by Glasgow City Council, the Care Commission organised a joint inspection of the school with HMIE in August 2004. This inspection confirmed that there were serious deficiencies in the ethos of the school, in its management, practice and child protection arrangements. Subsequently the Care Commission took formal action to ensure that improvements to the service were made. Notwithstanding this, there remains concerns about the contribution to safeguarding made by the external inspection process.

4.9 In the course of the investigation we have also identified a number of concerns in national safeguarding arrangements as expressed in the introduction of the Protection of Children (Scotland) Act 2003. This legislation was intended to strengthen national safeguards for children and young people through greater information sharing, detection and use of the disqualification listing. The Kerelaw investigation has been a significant test for this legislation, and the Council has made a total of 20 referrals to the disqualification list.

4.10 The process of referral to the Scottish Executive itself has been lengthy, and our experience has illustrated that there are some limitations in the legislation. We have referred individuals about whom we have concerns but have not

been able to investigate and some have been placed on the disqualification list. Some individuals are now employed in other care settings across Scotland, and the legislation and associated processes require the Executive to notify the employers of the concerns but do not compel those employers to carry out investigations or risk assessments on these individuals, although some have chosen to do so. We have had ongoing discussions with the Scottish Executive on this, but would want to take the opportunity at the conclusion of the Kerelaw investigation to initiate a discussion with the Executive on our experiences of these processes and our concerns around the limitations of some elements of it.

5. Our Response

5.1 In addition to the disciplinary action taken against individuals and the decision to close Kerelaw a number of actions were undertaken to address the findings of the investigation, including:

- The ongoing work of the Social Work Safeguarding Group, which is chaired by a senior manager, and has undertaken the development of safeguarding training across Social Work Services, the development of safe recruitment processes in our provided residential units, the strengthening of processes to review violent incidents within care settings and the development of a safeguarding action plan;
- We have strengthened the external management of our own provided residential services, and have external managers who have responsibility to consult with young people and staff; supervise the unit manager; respond to Inspection Reports; sample unit log books, care plans, records, sanctions; deal with complaints; analyse violent incidents, absconding, substance misuse;
- Identifying and delivering training on staff recruitment and selection, financial management, health and safety, service redesign;
- The examination of outcomes for young people accommodated and the development of the recently approved strategy for residential children's services which involves the withdrawal from residential school placements over a 4 year period and a reinvestment in community based placements;
- The implementation of the Contract Management Framework for purchased services which allows us to systematically monitor the care provided in purchased services;
- The audit of care planning for Looked After and Accommodated Children and further work identified on care management and care planning in CHCPs;
- The implementation of the Integrated Assessment Framework, which should improve our approach to assessment;
- The introduction of an electronic web based package (Viewpoint),that encourages children and young people to directly communicate to the care manager their views about the care they are receiving.

5.2 Notwithstanding this action already underway it is recognised that further work is required and the next section identifies key areas for further action.

6. Conclusions and Further Actions Required

6.1 The abuse and wider issues uncovered during the course of this investigation have lead us to identify six primary areas for action. In some of these areas work was already underway, and some action was undertaken during the

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course of the investigation as issues were identified. The six primary areas for action are:

- **Listening to Children and Young People** –listening to children and young people effectively is a core skill and task underpinning all of our involvement and interventions with children, young people and their families;
- **Care Planning and Care Management** –effective care planning and management systems and practice should be in place and monitored to provide safe and effective care and interventions for young people;
- **External Management and Monitoring** –all our external management processes for provided and monitoring processes for purchased services should be of sufficient quality, authority and robustness to identify and address failings in safe care;
- **Personnel Processes** – our personnel processes require to be refined to address child protection responsibilities;
- **Use of Restraint** – we will restate our policy on the use of restraint, and ensure there are robust monitoring processes for its implementation;
- **External Scrutiny** – we will ensure that partner agencies are aware of their responsibilities in safeguarding children and young people, and that national external scrutiny mechanisms are operating effectively. This should form part of the contractual requirements between Local Authorities and providers. ADSW have been endeavouring to put in place a contract to this effect for a number of years. The assistance of the Scottish Executive to progress a National Contract similar to the work on Care Homes would assist this process.

7. Recommendations

7.1 Committee is requested to:

a) note this report;
b) note the action plan; and
c) refer to the Executive Committee concerns around the limitations of national safeguarding processes and the development of a nationally agreed contract with residential schools.

David Comley
Director of Social Work Services

Kerelaw Investigation Report

Action Plan

Action	Lead	Timescales
1. Listening to Children and Young People		
Raising professional practice and standards through the: • Dissemination of this report through a series of practice forum discussions to share failures in listening to children and identify specific actions to address; • Ongoing development of a listening to children module as part of the LAAC and Child protection training; • Continued focus within PTL training in child protection on monitoring of teams focus on listening to children. Circulation of the Kerelaw Report to other care groups for consideration with regard to other vulnerable groups	SMT CHCP Directors/Heads of Children's Services/Head of strategic Management Children's Services Learning and Development Learning and development	June - August 2007 August 2007 August 2007 June - August 2007
Care Planning and Care Management		
Raising professional practice and standards through: • Ongoing implementation of the Integrated Assessment Framework; • Continued focus within LAAC modules on safe care issues; • Development of practice guidance which sets out specific standards on safe care, e.g. face to face contact with Children & young people, contact outwith residential/foster home.	Heads of Children's Services/Project Manager Learning and Development/Safeguarding Group Heads of Children's Services (CHCPs)	February – December 2007 August 2007 August 2007

External Management and Monitoring		
External Management of Provided Services: Ensure that the Annual Report on Provided Residential Care reflects current activity in external management on the frequency and management of complaints, allegations, levels of absconding and monitoring of care planning activity.	Head of Strategic Management (Children's Services)	August 2007
Ensure that the Annual Report on Fostering and Adoption Services reflects current activity in external management on the frequency and management of complaints, allegations, levels of absconding and monitoring of care planning activity.	Head of Strategic Management (Children's Services)	August 2007
Present both reports to Social Care Services PDS Committee.	SWS Director	October 2007
Develop and implement central log of complaints, and allegations in all children and family services, from the existing systems.	Safeguarding Group	December 2007
Monitoring of Purchased Services Analyse first 3 quarterly returns from Children and Family Providers to identify potential gaps in Contract Management Framework that relate to safeguarding and require strengthening	CMF Group/Head of Strategic Management (Children's Services)/Safeguarding Group	June 2007
Development of a model within CHCP's which ensures the quality assurance of purchased care, with focus on integration of care management and contract management activity, including the development of an audit function for purchased provision within CHCPs.	CHCP Directors/Heads of Children's Services	December 2007

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Personnel Processes		
Review the current personnel processes and develop and action plan to ensure an effective child protection focus including: o systematic recording of investigations; o on-going scrutiny of staff conduct, particularly the ability to identify accumulation of concern; o evidence required to confirm abuse ; o support to whistle blowing activity.	Head of Personnel/ SWS/Corporate	August 2007
External Scrutiny		
Dissemination of this report across all partner agencies with focus on the shared responsibility for safeguarding. Discussion with national bodies on the issues identified in the course of the investigation.	SWS Director SWS Director	June - August 2007 August 2007
Use of Restraint		
Reaffirmation of T.C.I. as Council's authorised restraint policy in provided services and robust scrutiny of this by internal/external management. Clear reference to and monitoring of restraint policies in purchased services as part of the contract management framework.	SWS Director/Head of Strategic Management (Children's Services) Head of Strategic Management (Children's Services)	August 2007 December 2007