stage two investigation. The letter advised that as a result of this investigation neither Ms C nor Mr C's fitness to be foster carers had been called into question. That there had been a need for the agency to make improvements to their service, and that their compliance with this need had also been set out in this letter.

4.139 DB also explains the actions that are being taken to redress these matters through the inspection process.

4.140 Other evidence that CSCI had taken the issues seriously followed the outcome of the circulation of the stage three report to placing authorities by Ms C and Mr C and included their response to such organisations e.g. a letter dated 1st June 2004 to the Principal Operations Manager, Fostering and Adoption for a concerned local authority. This letter from DV included the following:

- That the report was prepared by an independent person for NCSC at stage three of a complaint process,
- That a copy of the report was sent to the complainants who have subsequently been sent a letter by DB with the actions to be taken,
- That the report was prepared for the Commission and not for publication,
- The actions taken in response to the findings of the report.

4.141 FINDINGS IN RELATION TO THE OWNERSHIP AND RESPONSE OF CSCI TO THE OUTCOME OF THE INDEPENDENT REVIEW.

(1) LH became the S.E. Region Director on 1st April 2004 and inherited the adjudication of RB dated 31st March 2004 under the auspices of the NCSC. This responsibility included

inheriting the stage three report from Ms D, and carrying out its recommendations.

(2) LH had misgivings about the content of Ms D's report However, she stated that she had to accept the report as it had been accepted by RB and sent to Ms C and Mr C.

(3) There existed therefore no quality assurance systems within NCSC that picked up on the issues of the quality of the report. This led to the report in its form being inherited by CSCI. LH, at interview, stated that she therefore considered herself to be "*between a rock and a hard place*" in owning the content of the report about which she had misgivings.

(4) There was a delay of one month between her receiving the report and taking any actions about it. This delay is explained by the fact that there was no permanent post holder in the Oxford office to whom the report could be discussed so as to take matters forward. The new post holder, DV came into post on 4th May 2004. LH did act quickly and a meeting with DV took place on 5th May (DV's second day in the post).

(5) The evidence of planning meetings that included LH, DV and PW to progress a strategy for responding to Ms D's report, the fact that they did not rebut ownership of the report, yet confirmed to Members of Parliament, solicitors and authorities who had been contacted in the complaints processes that they were taking the report and its content seriously that they bought forward the inspection of the agency and ensured that it was led by an independent and experienced inspector and that they appointed an external experienced inspector to oversee the management of the inspection, and that the inspection was to incorporate aspects of fitness of Mr and Mrs H, all bring me to the conclusion that CSCI did both own the

content of the stage three report and took actions in evidence of that.

4D. WHETHER OR NOT RELEVANT LEGISLATION, POLICY, PROCEDURE AND PRACTICE WERE APPLIED AND LESSONS TO BE LEARNED FOR CSCI

4.142 At the commencement of the stage one complaint in April 2002 no written complaints procedure existed for the new organisation called the National Care Standards Commission. This was not introduced until October 2002.

4.143 All staff interviewed confirmed that they were not aware of this procedure.

4.144 The inclusion of complaints that should have been referred back to the local authority complaints procedure about the issue of the placement of child X, indicates that staff were not aware of the criteria for complaints under the National Health Service and Community Care Act 1990 (LASS Act 1970) procedures as well as their own, where they existed. That the complainants had rights of recourse to appeal through those statutory procedures.

4.145 The stage two procedures also should not have been used for the complaints made by foster carers against an independent fostering agency. To do so was in full non-compliance with those NCSC procedures, which specifically <u>excluded</u> complaints about regulated services (such as a fostering agency).

4.146 The Fostering Services Regulations, which came into force on 1st April 2002, should have been used at this point to deal with the issues under complaint. However, as the complaint was started under the incorrect complaints procedure in April 2002, it seemed logical to those involved that issues of dissatisfaction with the outcome at one stage should be automatically referred on to the next stage, thus

compounding bad practice. Nobody checked whether it was appropriate to continue on the same lines, which it was not.

4.147 The Inspectors, Area Managers and Regional Directors of NCSC and CSCI were not aware of the National Fostering Regulations in respect of complaints concerning independent fostering agencies. None of these people were familiar enough with their own complaints procedure to realise that it excluded specifically the very issues about which the complaints concerned.

4.148 In pursuing those (wrong) procedures however, neither CC in her review/investigation nor RB in his guidance to CC, or in his adjudication, followed what those procedures actually said.

4.149 Confusion was compounded for the complainants when CC advised that her brief was not to investigate but to review at stage two. However, the outcome produced from her report included assumptions about the probability of a complaint being substantiated, which implies that some investigation element was also used.

4.150 RB also wrongly advised Ms C and Mr C that the stage three would be an investigation, whereas the procedure clearly states that this would be a review.

4.151 LESSONS TO BE LEARNED.

The management and handling processes involved in complaints matters were very new to the NCSC in April 2002. The organisation had taken over a function previously undertaken by local authorities and were applying new Regulations and National Minimum Standards (NMS) as required under the Care Standards Act 2000.

4.152 The complaints from Ms C and Mr C started with a telephone call on the second day of the existence of NCSC and concluded with RB's adjudication at stage three on its very last day of existence.

4.153 The written complaints procedure did not come into existence until October 2002.

4.154 It is very important to note and to acknowledge in some mitigation to inspectors, that they previously included investigations about regulated services in their daily routine when under the auspices of the local authority arrangements. And there still exists today the option of inspectors undertaking direct enquiries where it would be inappropriate to ask a regulated service provider to respond to a complaint. This would be for situations such as when a regulated service provider might remove evidence that could substantiate a complaint against them.

4.155 The field of complaints handling has undergone very significant change since the statutory requirements introduced on 1st April 1991 by the NHS & Community Care Act and on 14th October 1991 by the Children Act complaints procedures. Much learning, training and procedural guidance has been introduced, not only from Government departments, but also at local level through social services designated complaints officers and their networks. But this growth in expertise within the social services complaints arena, had not, generally, filtered through to the regulation and inspection functions of the NCSC.

4.156 Today we see the appointment of a Complaints and Service Improvement Manager within the CSCI in recognition of the specific skill profile that complaints handling now requires, and in recognition of its importance to service users and informing better practice at an operational level.

Commission for Social Care Inspection

4.157 The lesson to learn from the complaints handling of this case indicate the following:

- Inspectors and Regulators and Managers require specific training on the investigation process.

- Managers require training to enhance their understanding of all relevant complaints procedures that their services may align to. This to include NHS & Community Care Act, Children Act, Fostering Regulations and the CSCI procedures.

- Policy Guidance is required to clarify when complaints processes may be allowed to vary from the expected complaints procedure, so as to ensure that regulated services may still be investigated in circumstances when the following of Regulations (e.g. Regulation 18 Fostering Services Regulations) would not be in the best interest of the regulatory function. Such Policy Guidance to therefore indicate the manner in which such investigation processes link to the Registration and Fitness procedures and what outcomes from an investigation would inform the judgement concerning the fitness of a regulated service.

- Quality assurance systems need to be an intrinsic part of all process, be they registration, inspection, complaints or review functions.

- Distinction of role and function needs to be made between investigations and reviews. These should be supported by robust policy and procedural processes which are, in turn, linked to the quality assurance systems.

- The complaints procedures need to be re-written to reflect the above.

4E. THE IMPACT UPON, AND POSSIBLE DETRIMENT TO THE AGENCY AND THE H FAMILY AS A CONSEQUENCE OF THE CONSIDERATION OF THE COMPLAINTS MADE BY MS C AND MR C.

4.158 To determine the impact and possible detriment to Mr and Mrs H of the agency, I interviewed them on 6th May 2005.

4.159 The crux of any effect of the stage three report on Mr & Mrs H came about by its distribution by Mrs C & Mr C to local authorities who would be involved in placing children through the agency. Mr and Mrs H stated that it was not until May 2004 that they became aware of the content of this report.

4.160 From April 2004 they started receiving telephone calls from placing authorities who had received Ms D's report. The calls began shortly after the report had been sent to Ms C and Mr C by RB on 31st March 2004.

4.161 This became increasingly stressful for Mr and Mrs H as the number of calls increased. They were unaware of the reasons why concerns had been triggered in this way.

4.162 The main referrer for placement was a consortium (WMC) that represented 14 local authorities.

4.163 One of those, and the largest referrer for the agency, was a major west midlands local authority. Their contract officer, RM, confirmed in interview that he started to receive telephone calls from Ms C, as well as numerous faxes, about the content of the stage three report. He also received from her a hard copy of the stage three report on 20th April 2004 as well as copies of correspondence, including one from JP to Margaret Hodge, Minister of State.

Commission for Social Care Inspection

4.164 After receiving the stage three report, the local authority decided to suspend all future placements with the agency but to continue the existing placements on the basis that they would carry out their own review of the agency.

4.165 After further telephone calls from Ms C they confirmed to her that they would be undertaking this review.

4.166 They therefore started to review all of agency's policies and procedures. This was undertaken by their Monitoring Officer.

4.167 In May 2004 the WMC met and it was agreed that a joint review should be undertaken of the agency. This would be undertaken by RM and PS (Senior Commissioning Officer) from another consortium member local authority.

4.168 They undertook their review on 26th May 2004. They also wrote in June to all social workers who either had placed, or were placing children through the agency, about the services provided by them.

4.169 RM informed me that based on the responses from the 14 local authorities, they decided to lift the suspension of placements with the agency. The outcomes had been very positive and there was no evidence to continue the suspension of placements. They continued to be the major purchaser of placements from the agency.

4.170 Mr H informed this reviewer that the December 2003 inspection report mentioned those authorities for which the agency was an approved provider. The report (as seen) does state that the WMC and a further consortium (the PLC) have approved the agency. The report also states the counties in which foster carers reside and that referrals are accepted from all parts of the United Kingdom. Mr H believes that this information may have been used by Ms C to notify those authorities of the findings of the stage three report.

4.171 Mr and Mrs H advised that placements had been suspended by the WMC, PLC and a further local authority.

4.172 My investigation confirms that whilst the WMC did suspend making placements, PLC did not. They took to liaise with a local authority that undertook their own assessment of the agency and were satisfied with the findings. Links were also made to the WMC to confirm outcomes to their findings. Matters being satisfactory there was no suspension by the PLC.

4.173 As Head of Contracts for the PLC, BF was able to confirm that she had initiated her enquiries as a result of receiving telephone calls from Ms C in June 2004.

4.174 SB, Unit Manager, Placement Service acted on behalf of PLC Contract Team. He confirmed that BF sent him a copy of Ms D's report as the assessing authority, to take a view.

4.175 He interviewed Mr and Mrs H and spoke to DV and PS and produced a report that was sent to the PLC.

4.176 The outcome of his findings were that the concerns raised by Ms C and Mr C did not raise concerns now, that the company had moved on and learned from the issues raised. The PLC therefore had no reason to alter their contract arrangements with the agency.

4.177 Ms C and Mr C had contacted the WMC by telephone and in the provision of written information. They received a response on 13th July 2004 from PS, the Senior Commissioning Officer that explained in detail the methods they had used in exploring the work of the agency. In his conclusions he states that the Consortium is satisfied that the agency meets the CSCI registration standards and have in place arrangements that are acceptable to the Consortium. That the

concerns they had raised had been addressed and that the organisation had arrangements to safeguard the welfare of children.

4.178 Mr and Mrs H described how the effect of this caused them severe stress, and they struggled to reconcile how matters had moved to a point where they felt that there was a vendetta against them, led by Ms C. They also felt that by not stopping the circulation of this report, CSCI were "*aiding and abetting*" this vendetta.

4.179 The effect of this also extended to their family, which includes a young person for whom they were seeking a Residence Order. This child had been with them for 4 years.

4.180 Mrs H received a telephone call from the Children's Services Division of the local authority in question, requesting a meeting. It had already been decided by that they would place the matter of the Residence Order on hold. Later a solicitor's letter confirmed that legal funding had been withdrawn.

4.181 Mr and Mrs H obtained access to their files from the children's services office, and saw that it contained many press cuttings that included (wrong) statements that they had placed a child who was a child abuser. This added to their stress. That there were cuttings from The Times, The Observer, Community Care, Care and Health, Birmingham Post and Leamington Gazette. There were also letters from MPs and a copy of the record of Hansard.

4.182 Mr and Mrs H contacted the local authority about their actions and on 10th December 2004 received a response from AC, Head of Children's Services. This is a long letter but links the actions of staff in the local authority in relation to the matter of the Residence Order and the media coverage of the agency. The conclusion of that letter not only goes into detail about the way in which Mr and Mrs H were poorly treated and how flawed some decision making had been, but that

they (the local authority) could understand how Mr and Mrs H reached a view "*that you have been the victim's of malice or vindictiveness.*" The conclusion of the Head of Children's service review states that the evidence gathered points to "*inadequate and poor practice, including at a management level, rather than malice*". He shared their view about poor practice and apologised for the distress, anger and inconvenience that these events had caused Mr and Mrs H.

4.183 This reviewer was informed by Mr H that the matter is now the subject of a corporate enquiry by the local authority who are to employ an external consultant to undertake an examination of how these events occurred. This was later evidenced by being provided with the letter, which is from MP, Public Liaison Officer at the local authority in question.

4.184 It was this letter that led Mrs H to start receiving counselling with a therapist in July 2004, such was her distress. This still continues. Mrs H is left feeling that Ms C is trying to destroy her and that it has become personal.

4.185 Of the recent inspection in October 2004, (a direct consequence of the stage three report) this has added to the pressure and stress, particularly for Mrs H.

4.186 Foster carers had been calling asking why they were not getting placements from the agency. The agency sent a letter in September 2004 to their foster carers saying that they may read press coverage about them and to make contact with Mr and Mrs H if they wanted to discuss this.

4.187 Within their own family of five children, some were starting to ask questions about what was happening. The events had impacted on their family life.

4.188 FINDINGS IN RELATION TO THE IMPACT UPON, AND POSSIBLE DETRIMENT TO THE AGENCY AND THE H FAMILY AS A CONSEQUENCE OF THE CONSIDERATION OF THE COMPLAINTS MADE BY MS C AND MR C.

(1) The impact to the agency cannot really be separated from the impact to Mr and Mrs H, as they are very closely connected.

(2) There is a need therefore to clarify what the impact was. There are five. They are connected.

(3) The first is the impact on the fostering agency of the suspension of placements by the main placement body, the WMC. This lasted approximately three months. Referrals stopped. There was a consequence of financial detriment for the agency (this has not been quantified).

(4) The second was the temporary damage to the reputation of the agency during this three months period. The profile of the agency was raised by questions asked in an Adjournment Debate in the House of Commons, supported by the MP (JP) who was representing his constituent, Ms C. Questions were asked of the Secretary of State.

Articles in newspapers and professional journals raised questions, which accumulatively left Mr and Mrs H thinking that readers of such articles will believe that there "is no smoke without fire".

(5) The third was the impact on the staff at the agency due to these pressures and articles in the newspapers. Added pressures arose from the need for CSCI to bring forward their inspection as part of their strategy to address the recommendation in the stage three report from Ms D.

One member of staff wrote an emotional letter to SC, the Head of Complaints and Service Improvement at CSCI on 4th December 2004 explaining the stress and anxiety that she had experienced over the whole matter. Her views reflect disappointment and scepticism about the role of the regulator and particularly the unfairness in which she feels the system has operated to bring this matter to conclusion.

(6) The fourth was the impact to the agency of them putting on hold further development and training for foster carers, as part of extending the work of the agency.

(7) The fifth impact was on Mr and Mrs H, which is evident to see on meeting them. Mrs H was receiving counselling and during the course of this review withdrew as a director of the agency, feeling that her life was being destroyed by the pursuing of her by Ms C.

(8) They do blame the CSCI for not stopping the circulation of the stage three report.

(9) It is reasonable to deduce that if the stage three report had contained a disclaimer that it should not be used without the written permission of NCSC, then CSCI would have had more options to take action against the distribution of the report. The failure to notice that Ms D had not included such a disclaimer on her report is part of the failings by NCSC to monitor the quality of the report in total. This also applies to the lack of proper quality management of the stage one and stage two processes and reports.

(10) Therefore there is evidence that the failings of NCSC (inherited by CSCI) to manage the complaints report at stage three directly contributed to its wide circulation by Ms C & Mr C.

The consequence of which was for placements to be suspended, for additional reviews to take place, for policies and procedures to be re-examined, for articles to appear in the national press and for an Adjournment Debate to take place in the House of Commons and for the Secretary of State to become involved.

(11) That all of the aforementioned had a negative impact on the agency and a detrimental effect also on the health of Mr and Mrs H.

(12) At interview DV stated that they had sought legal advice about stopping the circulation of the stage three report by Ms C and Mr C, but had been told that this would not be possible.

(13) Whilst this might have been a legal view, I conclude that CSCI should still have written to Ms C and Mr C informing them that the report is the property of NCSC/CSCI and must not be circulated without their consent and that such consent is not granted.

(14) It is a matter of conjecture as to what the consequence of such a letter might have been, but the failure to attempt to stop the circulation of their report does CSCI no credit. This error of omission and inaction by CSCI allowed Ms C to circulate their report (which CSCI considered biased) unchallenged.

(15) The evidence therefore indicates that the agency and Mr & Mrs H did suffer detriment as a result of the way in which these complaints were handled by NCSC/CSCI.

5. CONCLUSIONS

5.1 There have been some serious errors on the part of NCSC in the commissioning, managing, decision-making, operation and quality management of their three stages of complaint handling. The detail is obviously in the chapters of the report and its findings.

5.2 If there is a common factor which permeates the complete process, is that the NCSC were not clear what the proper complaints processes were that should have been followed, what was expected in relation to quality control of reports and investigative processes, and their failure to put specifically in writing what they meant investigators/reviewers to actually do.

5.3 There was no formal training in investigative practices for inspectors.

5.4 The three stages of the complaints procedure took place for the duration of the complete life of NCSC, and clearly the organisation was not equipped to handle complaints at an operational or managerial level. Its procedures were ambiguous and not robust in either clarity of process, quality assurance, staff skill or management supervision, as they needed to have been.

5.5 This lack of clarity led to individual's interpretation about what they considered should be done at each stage in both a commissioning role and those executing those processes. At one level it must be said that no individual intended to either mislead or obfuscate the outcome of their contribution. Also that the organisation at that time 'inherited' practices concerning complaints handling from those who had operated their own systems in their previous Local Authority setting.

5.6 Ms D's interpretation of her role in "*reviewing the actions/inactions of the NCSC*" meant for her that it was a paper exercise only and did

not extend to checking out matters by interviewing staff. Her review role also did not identify what steps the organisation took (or did not take) to resolve the complaints at the earlier stages (as stated in the procedure). However, in the absence of issued guidance on this process and proper checking of the report, her interpretation of her role and what she decided to include or omit in the report, was hers to decide.

5.7 Ms D stated in response to a written question if, upon reflection she would have done anything differently, she stated *"I wrote my report as a result of considered reflection based on the material provided. I have had no reason or basis upon which to change my conclusions."*

5.8 RB's ownership of the report on his last working day in the existence of the NCSC was short-lived. He accepted Ms D's report, despite its obvious difficulties, and left staff at CSCI to inherit the report and its findings, despite their own misgivings about it.

5.9 Because the report had no statement on the front restricting its distribution, it became circulated by Ms C and Mr C to support their continuing confrontations with the agency. CSCI did nothing to stop this circulation.

5.10 The report identifies that there was already in existence Fostering Regulations that specifically refer to the procedure to be used when there is a complaint against a fostering agency, yet staff were unaware of these Regulations. This identifies how Inspectors need to become aware of all legislation that relate to the processing of complaints for a Regulated service.

5.11 The poor investigative practices used turned the complainants (Ms C and Mr C) into the subject of complaint. This was most inappropriate.

6. RECOMMENDATIONS

(1) That the Chief Inspector note the findings and conclusions of this independent review.

(2) Inspectors, regulators and managers require specific training on the complaints investigation process. Only those for whom competence is assured, should the task be delegated.

(3) CSCI should ensure that managers receive training to enhance their understanding of all relevant complaints procedures that their services may align to. This to include NHS & Community Care Act (LASS Act 1970), Children Act, Fostering Regulations and the CSCI procedures.

(4) That a complaints procedure should be produced which describes the way in which inspectors process complaints received about a Regulated service. That such procedures also show how the outcomes arising from a complaint link with the judgement of "Fitness" of the Registered provider, and the procedures that may follow to remedy any poor practices identified.

(5) Policy Guidance is required to clarify when complaints processes may be allowed to vary from the expected complaints procedure, so as to ensure that regulated services may still be investigated in circumstances when the following of Regulations (e.g. Regulation 18 Fostering Services Regulations) would not be in the best interest of the regulatory function.

(6) Quality Assurance systems need to be an intrinsic part of <u>all</u> process, be they registration, inspection, complaints or review

functions. This to include report format and clear criteria of the working brief.

(7) Distinction of role and function needs to be made between investigations and reviews. These should be supported by robust policy and procedural process that are, in turn, linked to the quality assurance systems.

(8) The complaints procedures need to be re-written to reflect the above.

(9) That good investigative practice should ensure that a complainant is treated respectfully, so as not to become the subject of the complaint. That evidence gathering is not reported as personalised statements about complainants.

(10) That clear and coherent communication and accountability arrangements are introduced between local area offices, regional offices and the central Complaints and Service Improvement Unit in the processing, responding and monitoring of corporate complaints. That such arrangements ensure that the handling of complaints is co-ordinated at all levels of the organisation and the accountability for the processing and monitoring of outcomes is specifically delegated.