mentalwelfare
commission for scotland

Justice denied

A summary of our investigation into the care and treatment of Ms A

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Introduction

Ms A is a 67 year old woman with a learning disability who has been in the care of the local authority since she was eight years old. Our investigation into Ms A's care was initiated in September 2006, after we were contacted by a housing association who were concerned about her vulnerability. They said Ms A had reported being raped. When they contacted the police, they discovered that similar assaults were alleged to have taken place previously. The housing association said that the social work department had not informed them of Ms A's history of assaults and her related vulnerability.

It appeared, from our initial investigations, that the services responsible for Ms A had been unable to protect her from a series of serious sexual assaults. These assaults had taken place over a prolonged period of time by several individuals most, if not all of whom, were known to Ms A. Four of these assaults were alleged to have been made by one person. We believe that the responses of health, social care and criminal justice services combined to deny Ms A access to justice.

No-one has been prosecuted for the alleged offences against Ms A. Those who pose a known risk to her safety remain at large within her community, while Ms A continues to endure a protective regime that effectively deprives her of much of her liberty.

A key motivation for our investigation was our strong conviction that the circumstances surrounding Ms A's experiences are not unique. We have made several recommendations that identify ways in which

- the Scottish Government
- NHS Boards
- Social Work departments
- Police
- Professional regulatory bodies

could improve our protective and judicial responses to people with a learning disability. We hope that, through the implementation of these recommendations, people will receive the protection and redress that the laws of Scotland have been put in place to provide.

A summary of our key findings

Access to justice

The UN Convention on Rights of People with a Disability places a duty on State Parties to ensure effective access to justice for adults with a learning disability on an equal basis with others. For a number of complex reasons, this did not appear to have happened for Ms A.

We believe that policy leads, managers and individual professionals in health, social care and criminal justice need to review their current practice, to ensure that people in similar circumstances to Ms A have the best chance of securing access to justice and protection under the law.

We found that staff were confused about their professional responsibilities when it came to reporting a crime that Ms A did not want to report for herself. Staff had varying degrees of knowledge of relevant legislation and organisational procedures. Awareness and training in these areas would have clarified their responsibilities and guided their responses.

There did not appear to be a consensus, among those caring for Ms A, about her capacity to consent to sexual activity. This contributed to Ms A's difficulties in accessing justice.

Ms A's assessment by psychiatrists and psychologists for competence as a witness was not informed by professionals who knew her best. We think that the assessment of an individual's capacity to be a reliable witness is far too complex an issue to undertake without the involvement of those who are closely involved in his/her ongoing care. There is also no clear evidence that professionals had considered how support and preparation might have helped Ms A to act as a witness.

Given the professional advice which said Ms A would not be able to be a competent, reliable witness, it is not hard to see why the Procurator Fiscal decided not to proceed to trial. We feel, however, that there is substantial evidence that proper training of interviewers and proper support of Ms A may well have enhanced her capacity to act as a witness. Recent changes in legislation, which aim to help vulnerable witnesses give evidence in court, are more likely to improve access to justice for vulnerable people if they are properly implemented.

Deprivation of liberty

We are satisfied that Ms A is protected from further risk of assault. However, we do have serous reservations as to the lawfulness of certain aspects of her current care plan. The levels of protection that have been put in place mean that she is barely allowed outside her flat without an escort. We believe that this level of restriction requires an appropriate legal intervention and the safeguards that would accompany it.

It was generally acknowledged that Ms A was most at risk from a small number of identified men. The fact that these men were not prosecuted has left Ms A at greater risk. Management of these risks has been through highly restrictive care arrangements. If the people who Ms A claimed (and others believed) had assaulted her had been brought to justice, her safety would be less compromised and these restrictions less necessary.

Stigma and attitudes towards people with a learning disability

We believe that underlying attitudes of some professionals towards people with a learning disability may have affected their response to the incidents and allegations that were reviewed as part of our investigation. We believe that this compromised the quality of her care and support, as well as her basic right to equal protection under the law. It is difficult to escape the conclusion that different standards were applied to Ms A because she had a learning disability.

Communication and recording

Our investigation found poor communication between all the key parties involved in Ms A's care. We think this meant that professionals were not fully aware of important information. This contributed to failures in keeping Ms A safe.

The recording of information in health and social work case files was often poor. At several crucial points health staff did not appear to have fully and clearly communicated their assessments of Ms A to their social work colleagues.

Neither the requests for a report on Ms A's capacity to be a competent reliable witness, nor the assessment by medical and psychology staff were effectively shared with social work colleagues. This had an adverse effect on the management of Ms A's care and protection.

Assessment of capacity to consent to sexual activity

There does not appear to have been a formal, multidisciplinary discussion of Ms A's capacity to enter into a sexual relationship and the implications of this in relation to mental health law. There was never a proper, considered discussion about potential offences under Section 106 of the Mental Health (Scotland) Act 1984 or under Section 311 of the Mental Health (Care & Treatment) (Scotland) Act 2003. This represented a fundamental flaw in the health and social work team's management of this case.

Risk assessments and risk management

Care staff were aware of the specific individuals and circumstances that increased Ms A's risk. However, these were never seriously addressed in risk management plans until more recently. As a result, Ms A remained at risk and was subjected to further assaults which could have been avoided.

Clarity about roles and responsibilities

There was often lack of clarity around the respective roles of professionals and agencies throughout most of the period under investigation. There was also a lack of clear leadership in the multidisciplinary team working with Ms A.

The role of the Community Disability Nurse was narrowly perceived by others involved in Ms A's care. If these nurses had been used more effectively as part of the assessment and management of Ms A's vulnerability, she may have been afforded better protection. The potential protective value of the Community Disability Nursing role was lost.

The MHO role seemed to be similarly constrained and was limited to the processing of applications for Guardianship Orders and provision of technical/legal expertise. The MHO's knowledge, skills and experience as a specialist social work practitioner could have formed a key contribution Ms A's assessment and care planning.

Key recommendations

Scottish Ministers should…

- Take note of the findings of this report and determine what additional guidance and/or amendments to legislation are required to ensure equal access to justice for people with learning disability.
- Refer this report to the Crown Office and Procurator Fiscal Service Equality Advisory Group for its consideration in developing guidance materials in line with recommendations of the Review of the Investigation and Prosecution of Sexual Offences in Scotland.
- Ensure that the membership of the Crown Office Procurator Fiscal Service Equality Advisory Group include people with knowledge and experience of learning disability and other mental disorders.
- Develop and disseminate good practice guidance for professional staff involved in the assessment of vulnerable adults' capacity to be competent, reliable witnesses in response to requests from the Procurator Fiscal Service. Such guidance should take account of the special measures which are now available for vulnerable adult witnesses in criminal cases, under the Vulnerable Witnesses (Scotland) Act 2004, as well as the need to consult with relevant others involved in the protection of vulnerable adults on a case by case basis.

- Ensure that the Procurator Fiscal Service, in making referrals to psychiatrists and psychologists for reports on the capacity of a vulnerable adult with mental disorder to be a competent, reliable witness, refer to the availability of special measures to assist vulnerable adults in giving evidence.
- Ensure that all 'appropriate adult schemes' across Scotland provide relevant information and training for appropriate adults in relation to special measures for vulnerable adult witnesses. They should also consider advising local schemes to undertake an audit of their ability to respond (with appropriate adults with sufficient relevant knowledge and experience) to referrals for people with learning disability.
- Review the operation of the Scottish Crime Survey to determine the best method of securing better data on the prevalence of crimes committed against people with learning disabilities in Scotland.
- Issue guidance on the relationship of local Procurator Fiscal Services to Adult Protection Committees so as to ensure their valued participation without compromising their independence.

The Social Work Department should…

- Review the findings of this report and develop an action plan in conjunction with its Adult Protection Committee partner organisations to address those areas highlighted in the report.
- Co-ordinate with its Adult Protection Committee partner organisations the development and implementation of multi- agency training on the subject of capacity and consent to sexual activity. Training should also focus on the shared principles and values which should inform practice.
- Co-ordinate with its Adult Protection Committee partner organisations the review and re-drafting of multi-agency protocols and procedures on the protection of vulnerable adults to take account of the implications of the special measures now available for vulnerable adult witnesses.
- Co-ordinate with its Adult Protection Committee partner organisations the development and implementation of multi-agency training on the relevance of these new special measures. Such training should also focus on the implications for professional practice in assessing the capacity of vulnerable adults to be competent, reliable witnesses.
- Review information sharing protocols and procedures with its Adult Protection Committee partner organisations to ensure that there are no procedural encumbrances to the proper sharing of information essential to the protection of vulnerable adults.

- Clarify the leadership of community learning disability teams and the roles of individual members of the teams. This should be done in conjunction with colleagues in the NHS Board.
- Re-assess with NHS Board colleagues, as a matter of urgency, Ms A's capacity and current care arrangements to determine whether she is able to give free and informed consent to the restrictions on her movements which have been seen as necessary to ensure her safety. Such an assessment should include a focus on whether current restrictions are seen to constitute a deprivation of liberty which should be sanctioned by the courts under the Adults with Incapacity (Scotland) Act 2000. Consideration should be given as to whether such an assessment should be undertaken by practitioners independent of the local authority and NHS Board.
- Re-examine and clarify the role and function of the Mental Health Officer in adult protection case conferences to ensure that their specialist training, experience and skill is used to best effect in contributing to the assessment and risk management of vulnerable adults with mental disorder in these circumstances.

The NHS Board should…

- Review the findings of this report and develop an action plan in conjunction with its Adult Protection Committee partner organisations to address those areas highlighted in the report.
- Co-operate with its Adult Protection Committee partner organisations in the development and implementation of multi- agency training on the subject of capacity and consent to sexual activity. Training should also focus on the shared principles and values which should inform practice.
- Co-operate with its Adult Protection Committee partner organisations in the review and re-drafting of multi-agency protocols and procedures on the protection of vulnerable adults to take account of the implications of the special measures now available for vulnerable adult witnesses.
- Review the professional support and supervision of community learning disability nurses with reference to the relevant findings of this report.

The Police Force should…

- Review the findings of this report especially as it relates to training needs associated with interviewing vulnerable adult witnesses with learning disability and the implications of special measures for vulnerable witnesses on their ability to provide competent, reliable evidence.
- Co-operate with its Adult Protection Committee partner organisations in the review and re-drafting of multi-agency protocols and procedures on the protection of vulnerable adults to take account of the implications of the special measures now available for vulnerable adult witnesses.
- Examine with its partner organisations, the functioning of the Appropriate Adult Scheme, especially in respect of the availability and training of Appropriate Adults. They must ensure that the pool of Appropriate Adults includes the knowledge and skills to respond to the needs of adults with learning disabilities who are referred to the service.

Professional regulatory bodies should…

- Examine their respective codes of ethics and professional conduct to ensure that they address the issue of the professional's reporting to the police of an apparent crime brought to their attention by a client when the client has refused or is unable to consent to this. Such guidance should address the issue of impaired capacity to consent to the reporting of the crime:
- The Scottish Social Services Council
- The General Medical Council
- The Nursing and Midwifery Council, and
- The Health Professions Council.

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