North Lanarkshire
Adult Protection
Committee

Strategic Case Learning Review Concerning Events Leading to the Closure of Care Home G

Lead Reviewer: Colin Anderson

30 September 2025

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Foreword

Judith Tait: Convenor, North Lanarkshire Adult Protection Committee

As Convenor of the North Lanarkshire Adult Protection Committee, I welcome the publication of this Strategic Learning Review Report in respect of the circumstances leading to the Large Scale Investigation (LSI) and closure of a care home in North Lanarkshire.

This report was commissioned by North Lanarkshire Adult Protection Committee, to provide a strategic analysis of partnership working within the context of local and national policy and legislation. It considers the extent to which North Lanarkshire as the host authority was enabled to effectively address longstanding concerns about care home G, its residents' wellbeing and safety, and the challenges inherent in the effectiveness of local monitoring arrangements.

The LSI shone a light on the interface between legislation and regulation, local and national policy, and variation in local authority practices. These were recognised as critical elements of the "system" that should enable services to ensure people have their needs and rights met and live safely and well within a care home setting.

These themes formed the basis of North Lanarkshire Chief Officers accepting the recommendation of North Lanarkshire Adult Protection Committee (NLAPC) that whilst unusual, there would be benefit in using the learning review model to consider the harm experienced by residents within the context of local and national systems. This would enable North Lanarkshire partners to identify where local systems change and improvement were required and importantly highlight the barriers that exist within national policy and legislation that could result in similar harm being experienced elsewhere.

The proportionate option chosen for the scope of the work was to undertake three individual learning reviews for adults whose risk profile represented the thematic findings of the LSI. In addition, the APC appointed an independent reviewer to work alongside the individual reviewers to develop and report on the learning from a strategic systems perspective.

On behalf of North Lanarkshire chief officers, I am pleased to share the findings of this report, and I would like to extend my thanks to all in North Lanarkshire and beyond, who have been involved in this programme of reviews for their expert knowledge and commitment to learning.

Lead Reviewer: Colin Anderson

Colin Anderson is the Independent Chair of Glasgow's Child and Adult Protection Committees and prior to that was Independent Chair of Glasgow's Significant Case Review Panel. In addition to conducting Significant Case Reviews for Glasgow city, he has also worked on case and service reviews with a number of other Scottish partnerships.

A former Director of Social Work and Housing at Midlothian Council, Colin is a qualified social worker with a post graduate qualification in child protection. He also worked with Scottish Borders Council where he held a number of operational and management posts in child and adult services. Colin also recently chaired the Child Protection Committees Scotland Neglect Subgroup.

Introduction

Summary of Circumstances Leading to Review

Care home G was an independent care home in North Lanarkshire registered to care for up to eighty adult residents with mental health problems, associated disabilities and health issues. Care home G opened in 2012, following the closure of another care home, on the same premises.

At the point of increased scrutiny in 2021, 71 residents in care home G had been placed there by seventeen local authorities across Scotland (placing authorities). North Lanarkshire Council (NLC) had not placed any residents since the opening of care home G, however one resident from North Lanarkshire did remain, through choice, having lived there from being placed into the previous care home on the same premises.

Both NLC and North Lanarkshire Adult Protection Committee (NLAPC) had expressed concern about the model of care at care home G for several years. In August 2015, as part of ongoing monitoring and assurance, NLAPC partners reaffirmed a lack of assurance regarding the experience and safety of the home's residents and reiterated that the model of care was such that it could not provide appropriately for residents, given their wide range of needs. This assessment was formed through ongoing multi-agency monitoring, and was shared with national partners, including all Chief Social Work Officers in Scotland.

Whilst there were periods of improvements recorded by the Care Inspectorate in the period from 2015 to 2021, NLAPC and NLC Social Services continued to be concerned about the model and care in the home. Following an Inspection by the Care Inspectorate in 2021, renewed concern regarding significant risk was raised by the Care Inspectorate which resulted in enforcement action being taken, leading to consideration, and undertaking of a Large Scale Investigation (LSI) by North Lanarkshire Council along with improvement and scrutiny intervention by the Care Inspectorate. Subsequently a proposal to cancel the registration was issued on the 25th of October 2021.

The LSI was commenced for care home G on the 5th of November 2021 following an escalation of multi-agency concerns following the Care Inspectorate inspection and the raising of adult support and protection concerns by the Care Inspectorate and other partners. The LSI concluded on the 7th of April 2022.

Parallel to the LSI, the Care Inspectorate had ongoing scrutiny activity regarding the home remaining registered due to the risks to people they had identified in the home and an Improvement Notice was issued which was not complied with and the Care Inspectorate raised an application at court to cancel the registration of the service. The provider appealed to the Sheriff Court against the decision to cancel registration. Following the identification of further risk to people the Care Inspectorate raised a further action seeking an order to cancel registration of the service and this process was overtaken by the care home going into administration and the company eventually being dissolved in January 2025.

Police Scotland Involvement

In December 2021, Police Scotland were notified that a Large Scale Investigation (LSI) was undertaken in respect of care home G. A robust multi-agency review was conducted resulting in thirty-one adult support and protection referrals being raised, spanning December 2021 to March 2022. The following key concerns were identified as part of the multi-agency review of the care home:

- Residents not being given the correct level of care as outlined in their care plans such as assistance at mealtimes and assistance attending the bathroom, etc.
- Lack of attention to the physical needs of individuals including adopting the correct apparatus to safely move residents or help them stand up and move around the care home.
- Lack of respect for individuals, their dignity, managing their risks and their personal hygiene.
- In some cases, evidence of neglect whereby residents have been lying on mattresses saturated in urine and individual rooms not being cleaned frequently or appropriately.
- Evidence showing a lack of care to support individuals' mental health. There appears to be a gap in the personalisation of this approach to ensure there are strategies in place for all staff to offer appropriate responses.
- Evidence of appropriate risk assessments not being carried out or kept up to date, which has exposed residents to unnecessary harm including injury.
- Lack of care and strategy around residents who are known to show sexualised behaviour, which increases risk to other residents and visitors.
- Individuals' records not being kept up to date to confirm when checks have been carried out, if medication has been prescribed or when incidents have occurred.
- Staff having power of attorney regarding residents' finances who have no capacity. There has been a lack of bookkeeping resulting in large sums of residents' personal money being unaccounted for.

The Police investigation subsequently focused on:

- Securing witness evidence from
    - Social Workers
    - Care Inspectorate
    - Medical Professionals
    - Care home G Staff
- Reviewing care plans and ASP Investigations with support from Social Work
- Obtaining statements from residents or relatives where not possible from the resident.
- Seizing relevant documentation; and

- Gathering evidence to prove any criminal offences.

Police Scotland thereafter obtained General Evidence Search Warrants under the Criminal Procedure (Scotland) Act 1995. These were executed on Friday, the 4th of March 2022, whereby the care home was searched and evidential documentation relevant to the Police Investigation was seized.

After a thorough Police Investigation and engagement with the Crown Office and Procurator Fiscal Service (COPFS), a draft report was submitted for consideration of offences being libeled under the following legislation:

- Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 Part 3 Ill Treatment and Wilful Neglect
    - Section 26 – care worker offence
    - Section 27 – care provider offence
- Mental Health (Care and Treatment) (Scotland) Act 2003, Section 315 Ill-treatment and wilful neglect of mentally disordered person
- Corporate Manslaughter and Corporate Homicide Act 2007

Significant deliberations were made by COPFS and ultimately after reviewing the threshold of criminality it was deemed not to have been met.

COPFS decision was formally communicated at an operational meeting with Police Scotland on the 21st of January 2025.

The LSI report reflected significant concerns of systematic and ongoing harm and risk of harm to the residents, along with background information of long-term concerns and history of multiagency monitoring arrangements of the home.

As of the 4th of March 2022, there were no residents remaining within care home G, and the care home closed voluntarily and subsequently filed for administration. However, there remained no clear grounds to prevent similar models of care occurring or the development of similar risks in other homes. Scrutiny of other independent providers of specialist residential care has increased in North Lanarkshire since these events.

Decision to undertake a case learning review.

In accordance with national guidance, North Lanarkshire Adult Protection Committee agreed that there may be learning to be gained through conducting Case Learning Reviews in respect of three former residents of care home G. Individual case reviewers were appointed to lead each of these reviews, and all had the status of a stand-alone case learning review, adhering to national guidance.

The reviews were subject to the governance of North Lanarkshire APC. It was also agreed that the three individual learning reviews should be supported by an independent lead reviewer who would also be responsible, in conjunction with a strategic oversight group, for analysing findings from the three reviews. The Strategic Case Learning Review was also tasked with identifying

systemic learning which may have wider strategic implications for North Lanarkshire APC partner organisations, placing authorities, national government, and regulatory agencies.

Criteria for Undertaking a Learning Review

In accordance with National Guidance for Adult Protection Committees Undertaking Learning Reviews, APCs will undertake a Learning Review in the following circumstances:

1.Where the adult is, or was, subject to adult support and protection processes and the incident or accumulation of incidents gives rise for reasonable cause for concern about how professionals and services worked together to protect the adult from harm, and one or more of the following apply:

(i) The adult at risk of harm dies and

- harm or neglect is known or suspected to be a factor in the adult's death.
- the death is by suicide or accidental death.
- the death is by alleged murder, culpable homicide, reckless conduct, or act of violence.

Or

(ii) The adult at risk of harm has not died but is believed to have experienced serious abuse or neglect

2. Where the adult who died or sustained serious harm was not subject to adult support and protection processes

(i) When the findings of an inquiry or review by another organisation or court proceedings, or a referral from another organisation gives rise to reasonable cause for concern about lack of involvement in relation to the Adult Support and Protection (Scotland) Act 2007, or

(ii) The Adult Protection Committee determines there may be learning to be gained through conducting a Learning Review.

The APC Learning Review Executive Group (LREG) and Public Protection Chief Officer Group (PPCOG) are content that this review meets the criteria required to commission a Case Learning Review.

Rationale for undertaking a Review

In accordance with the national guidance, North Lanarkshire Adult Protection Committee (NLAPC) and PPCOG agreed that a Learning Review would support local improvements and should consider the impact on wider and national policy, models of care and legislation.

Terms of Reference

Where possible the terms of reference have been kept consistent for this strategic learning review and for the three individual learning reviews.

The LSI and regulatory scrutiny of care home G emphasised the importance of understanding the role of legislation and systems in relation to:

Independent providers of residential homes of specialist provision

Residents placed by local authorities from out with North Lanarkshire

Where the population of the home leads to increased propensity of general or specific health needs in one geographical area/ Health locality

It was also significant that at the conclusion of the LSI review on the 11th of February 2022, 23 service users remained under the Adult Support and Protection legislative framework.

It was accordingly agreed that this strategic Case Learning review (CLR) and the three individual CLRs should consider the following key aspects:

- How assessment, care and risk management processes were implemented for residents to achieve positive outcomes.
- Consideration of how national and local guidance, policy, procedures, and legislation affected the care, assurance, and monitoring of the residents.
- Consideration of how the adult's needs were safeguarded, with specific consideration of institutional harm and neglect.
- Consideration of the model of care provided at care home G and how effectively this type of provision consistently met the needs of the residents.

Review Process

Governance and oversight of the process was through an Extended Learning Review Executive Group (ELREG) which in return reported to NLAPC. This reflected the wide-ranging complexity and scope of the review.

The Lead Reviewer was involved in all aspects of the individual reviews and worked with the review teams to look at the wider impact on practice and service delivery. The individual review cases were identified as illustrative of findings previously recorded from reviews of residents at the LSI stage.

The individual learning reviews were held in respect of residents who were placed by another authority. NLAPC invited the three placing authorities to be members of the Extended Learning Review Executive Group and the individual review groups.

The review did not seek involvement or information directly from the care home owner or staff. The care home is no longer registered and there is no direct contact in place.

In accordance with the national guidance, each individual review was supported by a review team, which had a crucial role in working with the reviewer to analyse and to look at the wider impact for practice and service delivery.

The Lead Reviewer was involved with the individual review teams in identifying key issues and learning. In terms of this strategic case learning review, the Extended Learning Review Executive Group functioned as the review team in helping to assess information from the individual reviews and in developing key issues and learning recommendations which may have implications for wider systems, policy, legislation, and regulation.

This review also draws on findings from the LSI, particularly in relation to contextual and environmental factors within care home G.

In addition to collating evidence from the individual reviews, the Lead Reviewer hosted a strategic workshop and follow up meetings with key partner agencies. There was also a meeting with representatives from the medical practice commissioned by NHS Lanarkshire to support residents at care home G. Findings from the Large Scale Investigation (LSI) are also referenced in the report.

Wellbeing strategy

Developed and implemented by Dr Susan Ross, Dr Phil Smith & Dr Claire Stewart, Consultant Clinical Psychologists, NHS Lanarkshire Psychological Services.

Prior to the commencement of this review (and the three individual reviews for residents within the care home), consideration was given to supporting the wellbeing of those participating. This was particularly prudent as a number of participants had been involved directly with the care home as part of the LSI, either as the LSI team, Care Home Liaison Team or the Care Inspectorate. Due to several complexities, the strain on staff had been apparent during events leading to the closure, and it was crucial to ensure a novel and multi-faceted support plan was in place to support those taking part in the learning review. Consideration was given to not only the cumulative impact on their wellbeing, but also their ability to participate fully, with the psychological safety to recall and reflect.

A comprehensive, multi-faceted wellbeing strategy was developed in collaboration with three consultant clinical psychologists from NHS Lanarkshire's Psychological Services. The approach was informed by literature on psychological trauma, and social psychology relating to the human and system factors that were anticipated to influence both the lived experience of staff participating in the reviews, and their ability to reflect on events. The novel approach had an overarching aim to provide staff with optimal conditions to support their psychological and emotional wellbeing during workshop sessions, and to ensure that those feeling overwhelmed were identified and supported to access higher intensity care if required. In addition to tending to the wellbeing of staff participating, the approach also hoped to increase insight and awareness of the systemic and process issues to assist their reflections, enabling deeper reflection and sense making.

Wellbeing workshops were designed for the Extended Learning Review Executive Group, the Management Group overseeing the three individual reviews, and participants in the reviews themselves. The content was similar, but pitch was tailored to the unique roles of these three groups of staff. Staff were invited to attend a workshop prior to the review workshops taking place. The session content and the process of delivery were designed to increase insight and awareness, individually and collectively, to:

- assist participants in taking care of themselves by making sense of their psychological and emotional experiences – from a psychological trauma and emotional perspective.
- sensitively support workshop participants to reflect and share.
- promote a sense of collective learning and togetherness in the task ahead.
- promote psychological safety and attunement within the group and provide a framework to enable inconsistencies or different perspectives or accounts to be more safely explored.

- use these insights and resulting emotional and psychological safety to gain insight into some of the processes that may have been at play, influencing attributions and decisions at the time, including splits across professional/multiagency groups, and blind spots in awareness.

The workshops, attended by multiagency staff, also enabled collective exploration of any trepidation, concerns and expectation of the review process. Further reflective wellbeing sessions were facilitated by the psychologists to support the review teams and workshop attendees throughout the process.

NHS Lanarkshire's Psychological Services staff support team also provided a member of staff to be present at each review workshop to support anyone who wished to access individual support during the session or offer personalised signposting to follow up support. One-to-one input was also made available for all staff who took part.

The approach received highly positive feedback from participants - not only in tending proactively to attendee wellbeing, but in promoting safety to enable reflective learning from a systems perspective within each learning review, particularly through exploration of the factors that potentially prevented good practice.

Extracts from Participant survey feedback:

"We are not often afforded time to reflect nor to consider the models behind our thinking. We need to do more of this. It was great to have the time, space and support to do so. I think it will have aided the overall value of what people have shared and ensured they felt comfortable and safe enough to do so."

"I think it was very important that the well-being sessions were held prior to the learning review and not after. I think these sessions contributed to the psychological safety of the participants. Those who attended felt that it was a safe space to participate in. These sessions contributed significantly to the free flow of the contributions made by participants."

"The conditions were present for open, honest, and reflective discussions, based on the viewpoints of individuals whether agreeing or not agreeing. There were difficult topics of discussion and information which was hard to hear however there was permission to share how people felt including frustrations and regrets."

"More of the same please. If all Learning Reviews took a similar approach, I think we would achieve better outcomes for all. It was great to see staff being supported, listened to and given a safe space to reflect."

Practice and Organisational Learning; Learning from Previous Reports

To facilitate analysis of key practice and organisational learning and to understand the regulatory context, it is helpful to collate information from a previous report, undertaken on behalf of NLAPC, which cross-referenced information published by the Mental Welfare Commission (MWC) on the 29th of October 2019, the Care Inspectorate Report from the 28th of August 2019 and the Care Inspectorate Report from the 18th of August 2021.

Care and Support – The Care Inspectorate reported (2019) positive reviews about various aspects of living at care home G. People said that staff were very caring and nice to them caring and nice to them, the food was good, and people enjoyed the many choices that were offered to them. People spoke positively about the activities that were available to them.

The Mental Welfare Commission Report (2019) also reported similarities during their visit to care home G as they reported that they saw staff interacting in a kind and caring manner with the residents and the residents were positive about their care and support.

The report from the Care Inspectorate from August 2021, however highlighted a decline in the care and support provided where people commented that “it feels like a prison”, “I don’t like it here”, “Rubbish, no activities”. During the inspection it was observed that people were sitting for long periods of time alone in the lounges or their bedrooms. There were issues highlighted at this time around the nurse call system not being accessible for everyone which highlighted that people were unable to get prompt help if they needed it. This compromised the person’s dignity, safety and wellbeing and physical needs. The report also highlighted a lack of activities for people to engage in.

Rights and Restrictions – The Care Inspectorate report from 2019 reported that people were able to walk around each unit freely and also between both buildings; people were able to access the gardens on their own or supported by staff.

This was also highlighted by the Mental Welfare Commission who reported that the main door of the unit was locked with a keypad entry which residents were able to have access to. The door remained locked to prevent unauthorised entry and general safety of residents however residents were able to come and go freely.

The Care Inspectorate report from 2021 reported that people were directed to a mealtime “sitting” and did not take into account the preferences of the residents. People were also not fully supported to maintain their skills and independence as they were not given any opportunities to be involved in the purchasing, growing, preparing and serving of their own food.

Staff Team / Leadership – The Care Inspectorate Report from 2019 reported that individual supervision sessions had taken place for staff but recommended that minutes could be recorded better, and action plans devised to make them meaningful.

The Mental Welfare Commission Report also reported that staff supervision was now in place on an individual basis and group meetings were being considered to ensure open and transparent discussion around improvement and monitoring.

The MWC report also made the following comment:

“During the visit we were concerned that several of the residents’ clothing appeared worn out and ill-fitting. We discussed this with the manager who said that they were in the process of checking what each resident needed in clothing and accessing their funds to ensure this was provided for them. We suggested that welfare/financial guardians should be contacted as appropriate and involved in this work, and that staff may need to contact social work to ask for financial reassessment of some residents. We were also concerned that a guardianship order had lapsed but the issues around why this had initially been granted remained. We will contact the local authority concerned separately to discuss this issue further.”

The 2019 Care Inspectorate Report highlighted that there were insufficient staffing levels within the home as people were unsupervised for long periods of time in areas where falls and incidents occurred. Staff training was highlighted as an issue. Staff were not trained in Mental Health diagnosis or treatment despite this being a care home that offered specialist support. They lacked the right knowledge, competence and development to support people in line with their capacity for improvement.

Care planning / Reviews - The 2019 Care Inspectorate report noted that care plans were in place for each resident, and they contained enough information on how best to support a resident. However, these required further development with residents and their families. Some residents required their fluid and food intake monitored, however there were gaps in the recordings. Staff were not aware of the importance of accurate and contemporaneous record keeping. Care plans were in place for each resident, and they contained enough information on how to support each individual. However, these required to be developed further with residents and their families. Reviews were completed for the majority of the residents and the manager had an overview of these. It was suggested that a copy of these were kept in a folder to ensure all care staff had access to these. It was reported that at times there could be delays in getting social workers to attend.

Concerns about reviews were also highlighted by the Mental Welfare Commission who reported that reviews lacked detail on the person's presentation and progress. There was a suggestion made at this time that reviews have a wider attendance to include social work staff and a clear note made of any invitee declining to attend. They also reported that the care plans in place were person centred, however lacked detail around diagnosis and specific interventions required and no outcome of care was identified.

The Care Inspectorate also reported that care plans contained enough information on how to support each individual, however they required them to be developed further with residents and their families.

Conclusions from previous reports

The findings from these three sources of evidence across 2019 to 2021 highlight that at points, care home G was operating as a good care home with good staff, was a good setting and had adequate management and leadership. However there appeared to be a major decline in the care and support provided from 2019 to 2021 and this was reflected in the Care Inspectorate Reports which were sampled. The service grades went from (4) Good and (3) Adequate in 2019 to (1) Unsatisfactory and (2) Weak in 2021 which subsequently significantly contributed to the care home closing following the Care Inspectorate taking further enforcement action.

Learning from Individual Case Learning Reviews, Strategic Workshops and Follow Up Interviews

Responses in this section are grouped under the following key aspects from the terms of reference which were applied to all Case Learning Reviews:

- How assessment, care and risk management processes were implemented for residents to achieve positive outcomes.

- Consideration of how national and local guidance, policy, procedures, and legislation affected the care, assurance, and monitoring of the residents.

- Consideration of how the adult's needs were safeguarded, with specific consideration of institutional harm and neglect.

The following strategic themes emerged from the individual Case Learning Reviews:

1. There was an overall lack of person-centred/individualised approach in the care of the residents, and in the oversight of the placements. There was found to be limited understanding or representation of the adult's experience of care or life within the care home. This reduced the Voice and Visibility of individuals and made it more likely that the impact of the care being provided was not fully recognised.

2. There was found to be a poor understanding of and minimal reference to the adult's history of life events and there was no evidence of an appropriate chronology. This increased the likelihood of their individual needs becoming lost within the care planning arrangements. For those without family members the risk was greater.

3. There was confusion about ownership of assurance for quality and safety and a reliance by the care home on another agency or professional in taking the lead or being responsible.

4. Wrong assumptions were made about care home G providing "specialist" care. There was a need for placing authorities to objectively assess the evidence for assertions and claims made by care home G and to scrutinise the criteria the service was registered for. Care home G was not registered as providing specialist care, but this became the agreed narrative. It should have been the role of the commissioning and quality assurance teams from placing authorities to seek evidence regarding the level of care on offer, and where necessary challenge against what was being provided. The Care Inspectorate pointed out that they must register a service in line with current legislation and care home G was accordingly registered to provide care for 80 adults with mental health problems.

5. The Large-scale investigation process did not facilitate the swift investigation or resolution of concerns due to obstacles the care home was able to put in place.

How assessment, care and risk management processes were implemented for residents to achieve positive outcomes and how national and local guidance, policy, procedures, and legislation affected the care, assurance, and monitoring of the residents.

In addition to findings from individual Case Learning Reviews, we heard evidence of individuals being transferred to care home G under terms of section 13ZA of the Social Work (Scotland) Act 1968 as amended, without recourse to any other statutory measures. As things stand, it is still possible for a partnership to transfer a person to a residential provision in another authority under terms of 13ZA, and for there to be no other statutory measures in place or underway, such as Welfare Guardianship Adults with Incapacity (Scotland) Act 2000. We heard from one partnership that they had introduced a policy whereby any placement of an adult with complex needs under 13 ZA must then be followed by an application for either private or local authority guardianship (which would have implications for the host authority).

There is however a general duty of care and welfare on the placing partnership under the terms of Section 12 Social Work (Scotland) Act 1968, although this is not specific and does not appear to be defined in regulation or guidance.

Should there be a requirement to undertake welfare guardianship or to address any referrals under the terms of the Adult Support and Protection (Scotland) Act 2007, this would have, and still would be, the responsibility of the local authority where the regulated service is situated. In the case of care home G, that would have been North Lanarkshire Council.

The responsibility for undertaking care placement reviews and reviews of care plans becomes a requirement for the regulated service provider but again the specific responsibilities of the placing authority are not clear.

We found that each placing authority involved in the individual CLRs had their own internal policies and practice guidance which required an approach to care placement reviews that mirrored the statutory requirements for regulated care service providers.

The relevant legislation covering care reviews is The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 - namely regulation 5. This states that within 28 days of moving into care, a personal plan must be drawn up detailing how the person's health, welfare and safety needs are to be met.

Also contained within Regulation 5 is the need for the care home to review the personal plan, at least every 6 months OR when requested to do so by the service user/their representative and/or where there has been a significant change to the person's circumstances. It is important to emphasise that the legislation places a duty on service providers and not social work or Health and Social Care Partnerships.

We also heard evidence from individual case learning reviews concerning the complexity of legislation that underpinned placements. We heard how this could lead to confusion between, for example, which authority held responsibility for assessments and the initiation or implementation of legal orders or responsibilities, including from Criminal Justice, Guardianship and Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland Act) 2003 and Adult Support and Protection systems.

We heard evidence that in the case of care home G reviews could take place as a “desk top exercise" and without the placing partnership or host authority being advised or represented. One reviewer described the approach to care reviews as “perfunctory”. Reviews, when held in person, were often in a room designated for the purpose and there was often no opportunity to view the resident’s room or to see their personal belongings, e.g., the adequacy of clothing. Individual Learning Reviews talked about a lack of professional curiosity on the part of placing authority staff involved in reviews.

There was not always evidence of individual care plans being scrutinised and there was a notable absence of individual and environmental risk assessments.

Advocacy support was often absent, and it was not clear how the service was engaged and involved.

In terms of medical support, we heard that the GP Practice was awarded an Enhanced Service Contract by NHS Lanarkshire in 2011. This involved exclusive responsibility for GP services to all residents, irrespective of their placing authority. A GP attended the home for two sessions per week, with emergency visits as required. We heard that residents were usually brought to a dedicated clinical room at the front of the home, and the medical needs of residents were triaged by the care home G managers before referral to the GP.

On occasions a resident would be seen in their room but the GP who had lead responsibility for the service did not note any adverse environmental factors and, in any case, did not see it as their role to do so.

In general, the GP practice reported a good working relationship with the nursing staff but, as designated managers turned over, they reported a variance in managerial experience and expertise.

We heard that initially there was also twice weekly support from NHSL psychiatric services, but this was subsequently withdrawn and replaced by a private service directly employed by care home G. Allied Health Professional (AHP) services, such as podiatry, were also directly commissioned by the care home.

The individual reviews mention a lack of proper clinical psychiatric oversight, which is concerning. Those subject to measures contained within the Mental Health (Care and Treatment) (Scotland Act) 2003 require an identified responsible medical officer and a designated mental health office. Those with significant psychiatric diagnoses should also have regular medical review.

The GP was not involved in formal care reviews of individual residents and was not asked to contribute to this process, nor would they have allowed the time to do so within the constraints of the contract.

The GP Practice described their relationship with North Lanarkshire Social Work Services, in terms of ASP and AWI referrals as “tricky”. In general terms, the GP practice did not feel NL Social Work Services involved them in decision making either on a case-by-case basis or in terms of the closure arrangements for care home G. For example, it was not always clear why AWI medical assessments were being asked for.

There was a sense of medical services e.g., GP, Psychiatric and AHP not being joined up and coordinated. There was also a disconnect between medical services and the social care and wellbeing review process.

The Practice Manager described how, once the Enhanced Service contract had been awarded, they were “left to get on with it.” There was no sense of liaison or review of the contract with or by NHSL Primary Care, or the opportunity to renegotiate terms. We heard the Practice was not aware of a designated clinical pathway for the Practice to aggregate or escalate concerns for the medical care of residents. There was no sense from the Practice that these contracts were audited or inspected by an internal or external NHS regulatory body.

We heard that the Practice Manager was simply told that they could exercise a six months’ notice of termination clause but would still have the patients registered on their list.

In summary, although the GP viewed their support as of a good standard, there was no sense of an integrated approach to health and social care for care home G residents.

The Practice Manager described an alternative model whereby NHSL could deploy an integrated care home team including doctors, nurses and AHPs. However, we were also given an example where a single care home could have residents supported by five different GP practices. NHS Lanarkshire subsequently gave evidence that there had been only one instance when the integrated care home team had been deployed and this was not standard practice.

Consideration of the model of care provided at care home G and how effectively this type of provision consistently safeguarded the needs of vulnerable adults with specific consideration of institutional harm and neglect.

Care home G was often described in review team meetings as a "placement of last resort” or a “place and forget” option for vulnerable adults and that perhaps goes some way towards explaining why many placing authorities did not take cognisance of the letter issued by the Chief Social Work Officer (CSWO) in 2012 advising of their concerns for the quality of care at care home G. There is no evidence of any CSWO following up on the original letter, for example checking whether the situation had improved.

We heard from individual learning reviews that placing authorities made wrong assumptions about care home G providing “specialist” care and how there was a need for placing authorities to objectively assess the evidence for assertions and claims made by care home G and to scrutinise the criteria the service was registered for. Care home G was not registered with the Care Inspectorate as providing specialist care, but this became the agreed narrative. As stated directly in one of the individual learning reviews, it should have been the role of the commissioning and quality assurance teams from placing authorities to seek evidence regarding the level of care on offer and, where necessary challenge against what was being provided.

Review team members wondered how this model was compatible with the findings in the

Scottish Government’s Coming Home Implementation report.

We heard that seventeen different local authorities made placements at care home G. As things now stand nationally, there would appear to be no central register, record or research regarding

which authorities have placed individuals with complex needs in which establishments and under which legislation.

Under legislation, there is no distinction between the terms of regulations applicable to different types of care homes, but the Care Inspectorate gave evidence that they differentiate in terms of (a) applying appropriate conditions of registration and (b) inspection based on the question "Is this care home meeting / capable of meeting the needs of those who are actually resident there?" Care home G was registered as a care home for eighty adults with mental health problems with the Care Inspectorate and this was on the services Registration Certificate and the Care Inspectorate website.

In the workshop, however, we did not hear reassurances that similar issues to those witnessed at care home G would not still arise at similar sized establishments offering regulated care to vulnerable young adults with a wide range of needs.

However, the Care Inspectorate subsequently stated that they have developed a Design Guide for services that informs registration, and this includes the size of services for different service user needs, and small group living locations in communities. These are available on the Care Inspectorate website and inform registration.

The adult care home design guide states:

'Care homes for other younger client groups such as those for adults with mental health needs should have no more than ten residents in total. Care homes for adults with autism and/or learning disabilities must have no more than six residents in total.'

The Care Inspectorate pointed out that it was also important to note that inspections are based on Health and Social Care Standards which are Human Rights and Person Centered based.

We heard evidence that planning applications are still being received for the establishment of care homes with a profile like that of care home G. However, the Care Inspectorate pointed out that as per the Public Services Reform (Scotland) Act, 2010, any person who seeks to operate a care service must apply for registration with the Care Inspectorate. All applications for registration are reviewed in line with the Act and secondary legislation therein. The Care Inspectorate will review the competence of the submission aligned to the services stated aims and objectives, with s60(2) of the Act permitting the Care Inspectorate to apply any conditions of registration which they see fit. This can include, but is not limited to, the overall size of the care service aligned to the 'Care Homes for Adults – The Design Guide'.

We also heard that, other than through standard local authority planning regulations, which are building focused, there is no cap on the size of such establishments, as there is, for example, with Children's Houses.

We heard of a current application to build a care home for 240 older people with more than one unit, each with its own registered manager. Although care home registrations can specify the numbers of residents in specific categories e.g., Elderly, Learning Disability, Mental Health, Physical Disability, and Illness, it can be difficult to track new admissions and shifts in resident populations within those criteria.

The Care Inspectorate pointed out that there are requirements regarding services having appropriately qualified staff, although they no longer require staffing notices. Staffing structures are reviewed as part of the registration process with the question ‘Please provide us with details of your staffing structure, based on the numbers and needs of people using the proposed service.' posed. They also require services to inform them of the whole-time equivalent staff providing direct care as part of the registration application. This is then assessed by the registration inspector in line with the stated aims, objectives, and needs of people.

In terms of qualifications of staff, this is set by the Scottish Social Services Council (SSSC). Staff working in social care must be registered with the SSSC, who then ensure they have achieved or are working towards the appropriate qualifications for working in care homes. Nurses working in care homes must be registered with the Nursing and Midwifery Council (NMC) who are responsible for ensuring nurses have appropriate qualifications and that they keep skills up to date for the role they undertake.

It is the provider’s responsibility to ensure staff registration is in place. The Care Inspectorate ensures all providers have appropriate policies and procedures in place and through scrutiny take appropriate actions including referrals to SSSC and NMC for breaches of this or concern about staff practice.

We heard that in the case of care home G it was difficult to maintain an accurate and up to date picture of the workforce required to meet the needs of the resident group.

We heard that the owners of care home G were difficult to engage with and often threatened with litigation when confronted by regulatory authorities or by action under Adult Support and Protection (Scotland) Act 2007. It was also felt that people were hired to positions of responsibility who would collude with the owner’s perspective rather than comply with their own professional registration body.

In addition, the factors identified as influencing human behaviour and the lived experience of staff working within complex systems are applicable to day-to-day practice as well as learning reviews.

While the learning and resulting recommendations relating to process and procedure are the focus of this review, it is imperative to also consider the human factors at play that influence how people implement policy, procedures, and guidelines. This review, and insight gained from the impact of the wellbeing strategy, suggest that further examination of what prevented good practice is warranted. Processes are all very well and good, but it is humans who need to enact them, and without a focus on the salient human behaviour factors, one can only assume a similar situation may be repeated in the future.

Although we heard from the Care Inspectorate that information sharing and the gathering of soft intelligence is much improved, participants in the Strategic Workshop felt that the current legislative and policy circumstances were such that a similar scenario to care home G could happen again.

We also heard assurances from the Care Inspectorate that, during inspections of services, the inspector would sample any care review records that were available and may also sample care reviews undertaken by the placing social work representative.

The Care Inspectorate subsequently expressed a view that their current relationship with the North Lanarkshire Health and Social Care Partnership (NL HSCP) senior management team was excellent. However, they described how there were previous issues around engaging with NLC regarding ASP issues associated with care home G. It was also felt that had the LSI taken place earlier, perhaps as early as 2012 when the CSWO letter was circulated, it would have helped clarify matters and focus attention on required improvements.

A counter view was also expressed by NLC that the Care Inspectorate should have been more proactive in addressing concerns within care home G and NL officers felt the Care Inspectorate did not provide the necessary information to support an earlier Large Scale Investigation.

It is my view that, in the learning context of this report, discussing the merits of both positions would not be productive. What is more important is that a regulatory and public protection policy vacuum created space for such contrasting views to exist and without the means to resolve the hiatus.

During the LSI process there were several concerns highlighted with regards to the environment. These were in relation to communal areas as well as residents' bedrooms. It had been observed by multiple professionals that there was a lack of staff presence within the dining and living room areas. This was noted to be of particular concern with residents who had been identified as at high risk of choking or requiring assistance with mobilising.

The LSI notes that care home G staff did not appear to acknowledge or have an awareness of the poor environment or appear to be motivated to undertake proactive action to resolve issues.

Specific Practice and Organisational Learning and Suggested Strategies for Improvement

In accordance with Learning Review Guidance, we need to agree whether the following identified learning outcomes are unique to this case or have wider system implications.

Effective Practice

In October 2012 North Lanarkshire Council's quality assurance system was able to aggregate concerns from the care reviews of individual residents and initiated a decision-making process to terminate all placements at care home G. This also involved the Chief Social Work Officer writing to colleagues across Scotland advising of these concerns and of North Lanarkshire's decision to end all placements.

The standard of GP support was high, and the appointed practice was very diligent concerning their responsibilities under the Enhanced Services Contract.

Learning Issue 1

We heard of a recent example where private providers had made a planning application for a very large residential care home catering for mainly out of area residents. We also heard that the standard private care home business model is based on approximately two thirds of residents being self-funders.

This Learning Review also identified how it is possible, despite registration requirements, for a provider to self-present and advertise as offering care for vulnerable adults with a range of social care and mental health needs and complex behaviours. Placing authorities do not always scrutinise the advertised claims of a care home, especially for what is described as difficult to place vulnerable people with complex needs. Indeed, we heard two worrying phrases being used in the context of this review “placement of last resort” and “place and forget”.

Planning regulations for new care home facilities appear to focus on the proposed physical building structures, physical environmental impact, and location.

Improvement recommendation

It is recommended that Scottish Government should consider an amendment to planning regulations to ensure that any planning application for a new care home should include consultation with and approach by the local Integrated Joint Board (IJB) and NHS Board. Approval of any application should be dependent on a “developer contribution” to pay for local support and quality assurance services.

Learning Issue 2

In this situation there appeared to be a significant disconnect between the roles of the Care Inspectorate as regulator, the role of the Mental Welfare Commission and the responsibilities of the placing and host councils’ responsibilities under Social Care and Adult Support and Protection legislation, including for Large Scale Investigations. The sequence of reports from regulatory and statutory bodies sometimes appeared to conflict in their judgements regarding the quality of care and there was no clear system whereby these different judgements could be discussed, and joint actions might be agreed.

Also, there was no system whereby individual needs and risks identified in individual care reviews could be aggregated and reported to inform and alert wider quality assurance systems. This was made especially complicated by the fact that so many placing authorities were involved, and the host authority did not have any individuals placed in the home.

We also learned that some staff at care home G felt intimidated by the owners when speaking to regulatory and local authority professional staff. There was also a risk of professional staff feeling intimated by threats of litigation by the owners. Regulatory and local authority officers need to be mindful of creating a safe space when speaking with care home staff and need to recognise where staff might feel threatened or coerced by employers.

The Care Inspectorate felt they did everything within their powers to create a safe space and opportunities for staff to disclose concerns but point out that as regulators they could challenge but not control a situation where an owner might intimidate staff and demand they make agreed statements and report back to them (the owners) following discussions with inspectors.

Improvement Recommendation

Scottish Government should review the roles, powers, and responsibilities of statutory regulatory bodies and local IJB/HSCP and NHS Boards in order to ensure they are enabled to deliver a more coordinated approach to quality assurance and adult protection within regulated care homes.

Improvement recommendation

National Guidance for Large Scale Investigation should reflect the ASP Learning Review guidance and should be based on systems theory with a joint workshop at the heart of any methodology. The workshop should, as a minimum, include representatives from host and placing authorities, local NHS services, Care Inspectorate, Mental Welfare Commission, local advocacy service and if appropriate, the service provider and Police Scotland.

In this case we observed gaps and disconnects between the approaches taken by regulatory bodies and the host and placing authorities.

This should include a process whereby care quality standards addressed by individual care placement reviews are aggregated and collated within the host authority's quality assurance system. This in turn would trigger early identification of the need for intervention, for example through a Large Scale Investigation.

Learning Issue 3

In this situation there were adult support and protection issues generated by the extremely diverse needs and risks arising from a complex mix of vulnerable adults and from their living environment. It seemed that care home G could advertise as an establishment which catered for people with a range of complex additional needs without having to comply with any specific registration requirements.

We heard from one of the individual learning reviews that the individual had several "failed" placements in his own authority and had been labelled as "hard to place". We were advised that this was also the case for many of the residents.

Improvement Recommendation

The Scottish Government review of definitions of care services should strengthen the regulations, requirements, and conditions of registration.

This should include:

- That registration requirements and conditions can be used to specify the services a provider can offer to meet an individual's complex needs.
- Services should be required to meet standards and have the staffing levels.
- Specific registration requirements should take account of the cumulative impact of mixing people with a range of complex needs and behaviours within a single institutional setting.

The Care Inspectorate is of the opinion that even with the implementation of this recommendation, it will not stop providers advertising other services, as was the case with care home G and, in their opinion, will not make placing authorities undertake due diligence. This observation by the Care Inspectorate reinforces the need to take a whole systems approach as reflected in **Learning Issue 6** of this report.

Learning Issue 4

We were advised that Social work (Scotland) Act 1968 13ZA was frequently used to admit residents to care home G. This was based on the individuals lacking the necessary capacity to make decisions about how and where they should receive social care services. While 13ZA may have been an appropriate legal mechanism to underpin the moves for some people to care home G, in some cases there was no further follow up concerning the person's capacity; the need for guardianship to make longer-term welfare decisions was not considered; or advocacy on behalf of that person was not offered.

We were also advised that adults were admitted to care home G subject to an order under the Mental Health (Care and Treatment) (Scotland) Act 2003. There was no further follow up concerning the adult's rights when the order was revoked or lapsed, which could, in some instances, be seen as de facto compulsory detention.

Effectively, the requirements underpinning the original use of 13ZA to facilitate moves were never re-assessed in line with Adults with Incapacity legislation. People who continued to lack capacity to make certain welfare decisions remained in care home G without any legal grounds for longer-term welfare decisions to be made on their behalf.

There was no evidence of compliance with the Scottish Government circular, Guidance for Local Authorities: Provision of Community Care Services to Adults With Incapacity.

A member of the review team pointed out that a recent Scottish Government consultation on Adults with Incapacity had little to say on the use of 13ZA.

Improvement recommendation

Scottish Government should implement a policy to promote practice (already followed by some HSCPs) whereby any person admitted to a care home by application of section 13ZA should then be subject to assessment in respect of the need for Guardianship. If appropriate, this could then progress via either a local authority or private guardianship application.

There should be a statutory requirement that an independent advocate should be appointed in all such circumstances for the purpose of ensuring that the vulnerable person has a voice that is heard.

The Mental Welfare Commission published a good practice guide on Supported Decision Making in October 2024 and partnerships should ensure this is embedded in best practice.

Learning Issue 5

Medical support services for individual residents were fragmented. There was no sense of an integrated health and social care package for individual residents. A resident's need for GP, Psychiatric and Allied Health Professional services were triaged and commissioned by the care home. Care reviews for individual residents were not attended by professional staff from the local medical practice. There was no sense of environmental factors being considered in medical assessments.

Some NHS areas have had the services of an integrated care home team which included doctors, nurses and AHPs but we heard evidence that these arrangements have not been sustainable, and most Health Boards have moved away from them.

Improvement recommendation

Scottish Government should ensure where the deployment of medical integrated care home teams is no longer sustainable, that NHS Boards have satisfactory arrangements in place to take account of the individual and collective impact of medical needs arising from vulnerabilities of care home residents. It should also be clear how these medical care arrangements are monitored, coordinated, and contribute to an integrated health and social care plan arising from individual care reviews. In this respect, specific attention should be paid to resident's personal living environment and care arrangements.

Learning Issue 6

As previously described, the responsibility for the organisation and management of individual care reviews lay with the owners and managers of care home G. We heard that reviews were sometimes "desk top exercises" and when conducted in person, families and professional staff from placing authorities were often shown to a room set aside for that specific purpose. The residents' individual rooms and communal living areas were not always viewed.

Prior to North Lanarkshire Council's decision to discontinue placements at care home G, there was an apparent disconnect between what NLC was seeing on the ground through care reviews for individual residents and what the Care Inspectorate was seeing during their inspections.

There was also an apparent disconnect between what placing authorities were seeing during their individual care reviews and the concerns NLC had previously identified.

The host authority, North Lanarkshire, had lead responsibility for progressing Adult Support and Protection responsibilities but did not have a role in care placement review processes. As noted previously, apart from one legacy placement for a period, NLC did not have residents placed in care home G and therefore was not sighted on any care home review activity.

We also heard from the Care Inspectorate that, in some partnerships, specific teams are appointed and attached to contract and commissioning sections, for the specific purpose of conducting reviews. The concept of contextual safeguarding is now common practice in childcare and protection, but the same consideration does not appear to apply for a care home resident's

living environment nor their interactions with staff and other residents. The impact of a complex mix of vulnerabilities and behaviours was not considered.

In this context, by contextual safeguarding we mean, for example, the physical environment, the quality and cleanliness of an individual's clothing and other belongings, the risk from other residents and the quality of relationships with staff members. Awareness of issues through a contextual safeguarding approach may also flag ASP concerns of neglect.

Also, there was no system whereby contextual safeguarding concerns arising from several, person-centred individual reviews could be aggregated and processed through a quality assurance and improvement system.

Improvement recommendation

Scottish Government should review section 5, regulation 5 of The Social Care and Social Work Improvement Scotland Regulations 2011 and move the responsibility and resources for leading on care placement reviews from the provider to the host authority with requirements on stakeholders, including the care home, local NHS services and the original authority of ordinary residence to cooperate as necessary.

This should include:

- The proposal that care management and funding responsibilities remain with placing authorities, addressing Ordinarily Resident situations where the host authority holds welfare powers, and mirroring statutory duties and obligations within the Adult Support and Protection (Scotland) Act 2007.
- Consideration of how private care home providers can be required to fund the coordination and chairing of care placement reviews by host local authorities to be included within placement fees charged against individual residents.

Overarching Implications from improvement recommendations

The improvement recommendations above are driven by systems theory and organisational learning but such a radical shift would come with serious resource implications for the host area and services.

Essentially, what is suggested gives the IJB/HSCP a key role in planning applications regarding new care homes and governance over the health and wellbeing of care home residents within their partnership area. This would also have serious governance and resource implications for Adult Protection Committees and stakeholder services, including NHS and Police Scotland.

As with current Adult Support and Protection legislation it is proposed that the Council and Integrated Joint Board would have a duty of care, but other organisations would also have a duty to support, collaborate and cooperate with the process.

A statutory framework in which the umbrella oversight of services sits with the host authority would, in effect, mirror ASP and Guardianship responsibilities and duties which legally sit with the host authority. Aggregating care home review outcomes, with an emphasis on contextual safeguarding, would allow an HSCP to build up robust quality assurance systems and a more effective support and protection system.

This would also create more effective partnerships, underpinned by a memorandum of understanding between placing and host authorities and with bodies such as the Care

Inspectorate and Mental Welfare Commission, especially around initiating and conducting Large Scale Investigations.

A memorandum of understanding already is in place between the Mental Welfare Commission and Care Inspectorate and this has recently been reviewed and updated.

For their part, the Care Inspectorate identified learning from care home G closure as having already been delivered. This involved a need to improve their working relationship with North Lanarkshire Council, and a review of training and procedures to make sure they are informed by care home G experience. However, the prospects for adults with complex needs who require residential care will only improve if the statutory and regulatory agencies work together within a joined-up system with an aim to provide better outcomes for the most vulnerable members of our communities.

Finally, I feel compelled to repeat that, given what I have learned from evidence presented to me and analysed in this report, individual residents were let down by the systems that were supposed to provide care and protection and it is my firm view that, unless the Learning Issues identified in this report are addressed, it would be possible for the circumstances which were found at care home G to be repeated.

Colin Anderson

30 September 2025