

Edinburgh's Children

The Report of the Edinburgh Inquiry into Abuse and Protection of Children in Care

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Foreword

Timescale

The Inquiry was formally established when we as members accepted the remit and invitation to serve communicated to us by a letter dated 21 January, 1998. Our original hope was that we would be able to complete and submit our report by late summer of 1998. That hope proved to be over-optimistic. A number of factors have contributed to the length of time our deliberations have taken, and the corresponding length of the report itself. These include: the broad scope of the original remit; the additional expectations placed upon us following receipt of an anonymous letter; and the import of what we discovered, in respect that it emerged that some of the former residents of the children's homes involved in the High Court case had tried to tell about their experiences in various ways from childhood right through to adulthood. We believed it was important to follow through, to the best of our ability, what happened to those reports. This involved tracing and speaking to many former members of staff.

Although the trial concluded on 4 December, 1997, there remained a possibility of further legal proceedings in respect of two other former members of staff. Further proceedings were also probable in respect of one of the convicted abusers who lodged an appeal against conviction in respect of two of the charges and further appealed against the length of his sentence. The appeal was not heard until 6 January, 1999. This had implications for our access to files which remained in the possession of the Crown. It also had implications for our ability to publish our findings. Generally accepted practice, based on sound reasons, is that publication of any report must be delayed until the completion of judicial proceedings. Indeed, it was suggested in draft Scottish Office guidance (referred to below) that inquiries should not commence until the conclusion of judicial proceedings. Whilst acknowledging the rationale for this, we are also of the view that, given the time-lags and uncertainties surrounding appeals and the possibilities of further prosecutions, following this advice strictly might mean waiting so long that the relevance of any such Inquiry was significantly diminished.

We considered in October whether there would be merit in submitting an interim report to the Council addressing the adequacy of current safeguards and proposals for the future. However, we were keen to ensure that the proposals for the future reflected back where appropriate to the lessons from the past. We concluded that an interim report which had that perspective excised would be difficult to explain and would perhaps be more frustrating than helpful.

The result of the appeal heard on 6 January 1999 has, we believe, exemplified the need to delay publication. Had we not done so, doubts might have been cast upon the relevance of some of our statements and conclusions. Now it is clear that what we say is said in full knowledge of the outcome of those proceedings.

Preparatory Work

We also had to devote time after our appointment to considering how we should discharge our remit. This was the first Inquiry held under the Children (Scotland) Act 1995. There was little precedent for inquiries of this nature. The Scottish Office helpfully supplied a copy of draft guidance, which had

never been formally issued, on the conduct of inquiries. We identified the inquisitorial approach as more appropriate than the adversarial. We had to consider the principles on which we would operate, and the level of formality that would apply. In this way we sifted out what we believed was over complex and worked out the method of approach which is set out in greater detail within the body of the report.

We had to set up office arrangements. Given the amount of concern expressed in the media, and subsequently in the anonymous letter, about the need for independence, we have kept the substance of the work very much to ourselves, relying upon the Council only for the necessary practical supports.

We had initially accepted our appointment on the basis of allocating two or three days per week to work on the Inquiry. The draft guidance from the Scottish Office had indicated that Inquiry members should be available to work full time. As time passed, we came to see the wisdom of that suggestion. At times we have been occupied full time on Inquiry work, although all three of us have also had other professional commitments. It is our view that this consideration should be taken into account when any future appointments are made.

Costs

We have at all times been conscious of the expense incurred by the City of Edinburgh in financing this Inquiry. We have no doubt that, although the incidents which gave rise to the Inquiry took place within the City of Edinburgh, the issues which we have addressed are by no means restricted to the City. If our proposals and recommendations for practice have the value which we hope they have, they will be of considerable relevance to the rest of the country. It seems unfortunate that the City of Edinburgh should require to pay the total cost when benefits might accrue to other authorities at no cost to them.

Closing Down

Earlier reports, such as that of the Fife Inquiry have shown how difficult it is to close inquiries down. We too were struck by the number of people who gave us just that little bit of extra information which we then required to check with others who had or might have knowledge of that subject.

The Remit with regard to the Present

The visits to residential units to speak to staff and current residents all produced ideas and information which we had to analyse, check with others and then reflect upon. They also produced valued evidence of the complexity of the responsibilities that fall on staff and foster parents who are charged with the duties of caring for young people, many of whom have already experienced troubled childhoods and present very special needs for their care. At the various units we quickly recognised the willingness and ability of the young residents to participate constructively in our work. One particular insight exemplified that willingness and sharpness. On a visit, a young resident challenged the oldest member of our team, "You shouldn't be doing this report." Mindful of the media comment about that member's perceived independence, he asked her why she thought that. "You're far too old" was her disarming reply. She had a point. Further enquiry disclosed that she thought the report should be written by herself and a fellow 15 year old resident. "However," she said "We're not very good at writing." An arrogant claim was made about the competence of the Inquiry team as writers, the validity of which can be assessed by those who read the report, and a compromise was reached with

an agreement that the residents would do the talking and we would do the writing. And talk they did, with much sense and understanding too. We hope that this exemplifies that we are not so much the authors of the report, but the distillers and analysers of the information which we received from staff and residents who themselves know about residential care. In that way, a significant contribution was made by the young people themselves.

The Remit with regard to the Past

The meetings with those who had already given evidence in the High Court trial were exacting experiences for those who came to see us. We reflect in the report the pain caused to those who were ill-treated and our appreciation of their co-operation. The passage of years and the need for us to cross-check distant memories with fellow residents added to our work. We were particularly impressed throughout with the oft-repeated desire which they expressed that what had happened to them must not be allowed to be repeated with those who are now looked after by the Council. In a few cases, that cause for anxiety arose through concern about the possibility of their own children or relatives finding themselves in that situation. Most however were expressions of general concern for any child who might be in the position in which they had been.

While we are aware that some of the victims are pursuing claims for compensation, we do not accept that for most of them their main interest is financial. What they want is recognition of the fact that they were abused and, even at this late date, an expression of regret or apology for the behaviour perpetrated upon them and the consequences for them, some of which are still apparent today.

Constructive Criticism

In the discharge of our remit with regard both to the past and the present, we have in places required to make particular criticisms. We have been anxious to adopt a constructive approach to that task. With regard to the past, we acknowledge the importance for the victims of a clear acknowledgement that what happened to them was wrong, and an explanation of how it could have gone on for so long without discovery, and why such reports as they did make received no satisfactory response. We have generally found that staff involved at that time, having discussed with us their own involvement in these events, have come to realise how things might have been progressed differently and have often been self-critical, whilst acknowledging too the different expectations and understandings of earlier times. We believe that our willingness to explore together with them what went wrong has encouraged them to be more open and honest with us, which has in turn helped us to look at the current safeguards in a more informed and critical way. There is little to be gained for current residents by a pure analysis of what went wrong unless the lessons for that analysis are learned by those who provide care now.

The report reflects our appreciation of the demanding and complex nature of the work carried out by those who care for other people's children, many of whom present special difficulties. The report also reflects a sense that residential staff are operating against a background of fear of disciplinary action. These fears were exemplified by a senior manager's leave of absence and suspension of staff in respect of historical allegations which formed part of our extended remit. It has been suggested to us by a number of people that this fear may inhibit workers from informing line managers of action taken or omissions made lest an interpretation be made that disciplinary action should follow. The report recognises that a balance has to be struck in regard to disciplinary proceedings and that suspension

can be appropriate and indeed essential for children's safety. We have concluded that nothing we learned in the course of our inquiry would in our view merit disciplinary action against any current member of the City of Edinburgh Council's Social Work Department staff. It would be a poor consequence for individual staff members who co-operated so fully and frankly with us, including reflection on whether or not they might have acted differently, if an interpretation were made that they should suffer penalties which arose directly from that co-operation. A parallel may be drawn from the Finlayson/Newman Report which forms part of our remit. On that occasion the then Lothian Regional Council accepted that the ready co-operation of staff was not to be held against them. We earnestly hope that the same approach will be adopted by the City of Edinburgh Council in regard to the contents of this report. It is our firm belief that the safety of children looked after by the Council is dependent on their being cared for by a secure, confident, able staff.

Just as the former residents are motivated by a wish that children in the future really should be safe, our findings and work on this report have the same aim. If we have provided a basis which will help the Council and their staff to improve the conditions and safety elements for children in the future, we will have discharged the debt we feel to those who have assisted us, and particularly to those former residents.

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1. INTRODUCTION

A. Background

1.1 Following the conviction of two former care workers on 4 December, 1997, the City of Edinburgh Council's Policy and Resources Committee agreed to hold an Inquiry under section 6B of the Social Work (Scotland) Act 1968 into matter arising out of the trial. The Committee agreed that we three be appointed members of the Inquiry team: Kathleen Marshall (Chair), Cathy Jamieson and Alan Finlayson. Brief biographical details are set out in Appendix 1.

B. Remit

1.2 The remit of the Inquiry was:

1. In relation to the recent High Court case to ascertain if there was any allegation raised prior to the commencement of the police investigation, and if so –

to determine if there were any reports which were not acted upon and, if so, why;

to determine the appropriateness of action taken at that time;

to identify any lessons that may be learned against the background of what is known of practice and procedure in place at the time (i.e., 1973 – 1987), additional to what may be contained in subsequent reports in this field.

2. To view current procedures, practice and guidelines in operation in the City of Edinburgh against the background of –

the High Court proceedings;

the Finlayson/Newman Report of 1993 – “Listen – Take Seriously What They Say”;

the Scottish Office Report – Children's Safeguards Review” (1997),

to determine:

what safeguards are in place;

the adequacy of these;

the uniformity of their application across the City;

what additional safeguards may be necessary.

3. To make recommendations as appropriate arising from remits 1 and 2 with a view to assuring the Social Work Committee and the public that every measure is in place to minimise child abuse.

4. To determine its own method of approach in discharging 1 to 2 having regard to the following timescales:

The audit of current procedures set out in paragraph 2 of the remit will commence as soon as possible, after the Christmas/New Year period. The commencement of the inquiry as regards paragraph 1 of the remit will be dependent on the availability of the Council's files which are currently in the possession of the Crown.

C. Format of the Report

1.3 Chapter 2 sets out our methodology. Chapter 3 sets the context for our remit by setting out the facts of the High Court case, profiles of the accused, and a portrait of life in care in the three establishments involved in the trial. Chapter 4 constitutes the main part of our report as regards the fulfilment of our remit, as it sets out reports reputedly made about the abuse before the commencement of the police investigation which led to the trial, and reaches conclusions as to whether the responses to these reports were appropriate. Chapter 5 also addresses the past with regard to the events alleged in an anonymous letter relating to two other residential units. Throughout Chapters 3 to 5, “Lessons” are set out in boxes. These Lessons are not necessarily novel and are sometimes repeated as the same issues may arise out of different sets of circumstances. They are set out in this way to draw attention to what we consider to be significant issues arising out of the preceding text. They are gathered together for ease of reference in Chapter 6. More succinct “themes” with regard to the events related to the High Court case are set out at the end of Chapter 4.

1.4 Chapters 7 to 21 consider the adequacy of safeguards for children currently looked after by the Council. Recommendations are set out in boxes within the text and are gathered together for ease of reference at the end of this report. However, we also considered it would be helpful to set out an agenda for action, to identify priorities and to indicate which of our recommendations we believe add significantly to the current debates. These matters are set out in Chapter 22.

D. The Decision to Omit Names

1.5 After a great deal of thought we decided to refer to individuals by designation rather than by name. We were always clear that junior staff who had paid no significant part in past events or who wished to express to us their view of current safeguards, should not be named. We were less clear about our approach to those in positions of greater responsibility. Our decision to omit names was influenced by our ultimate view that the failures of the past lay more with the system than with individuals. We also had to take into account that our method of approach was geared towards encouraging openness and did not involve the legal protections which would be associated with a court making findings of guilt. Further, given the passage of time and the fact that we were unable to contact some of those who had such responsibilities, either because they had died or because we were unable to trace them, we concluded that it would be fairer to indicate involvement by means of designation rather than by name.

E. Terminology

1.6 Since the introduction of the Children (Scotland) Act 1995, the term “in care” has been replaced by references to children who are “looked after” by the Council. We have tended to use the phrase “in care” with regard to the past and “looked after” with regard to our audit of current safeguards.

1.7 Where abbreviations have been used we have tried to explain them within the text. However, a few of the more common abbreviations are also explained at the end of this report.

2. METHODOLOGY

A. Principles

2.1 The Inquiry team first required to decide upon its method of approach. Our task differed from some other alleged abuse Inquiries in respect that prosecution had already established that abuse had taken place. That prosecution had been conducted in terms of the high standards of evidence and procedure required to establish guilt beyond reasonable doubt.

2.2 We had specific tasks to perform with regard to what had happened in the past. We had also to identify what lessons could be learned from these happenings. This moved the focus to the need to protect children now and in the future. While part of our task was to determine whether action taken in the past was appropriate, which involves an element of judgement, it seemed to us that our focus was the welfare of children rather than the determination of guilt. There was more to be gained by engaging in a positive way with those whose actions were being scrutinised, with a view to exploring with them whether the action taken was appropriate, than by resort to hostile questioning which would have resulted in minimal and defensive responses.

2.3 For these reasons, we decided that it would be more appropriate for us to model our procedure broadly on a children's hearing as opposed to a judicial model. That is to say, we should try to engage the relevant parties in frank and full discussion in a relatively informal manner rather than mimic the formal procedures of a court. We considered this to be an appropriate approach for what was the first Inquiry to be held under the provisions introduced by the Children (Scotland) Act 1995 (which had inserted the new Section 6B into the Social Work (Scotland) Act 1968), with its emphasis on the paramount importance of the welfare of children. We set out our proposed approach at a public meeting called for that purpose on 4 February, 1998.

2.4 The children's hearing system has recourse to a court to determine any disputed facts on the basis of the balance of probabilities. The Inquiry did not have this resource and had not constituted itself in that way. We therefore approached this matter as follows:

1. In those sections of the report where we are describing life in care, we present the perspective of the former residents as they described it to us.
2. Where we have identified facts that are likely to be disputed, we have tried to present both perspectives and have set out the basis of any judgement we have made.

2.5 The Inquiry had power to compel witnesses to attend, but we were quite clear that we would not put any pressure on the victims to attend, and that nothing would be gained by doing so. Nor did we ever need to resort to compulsory powers with regard to any other person. All those persons we were able to trace responded readily and constructively to our requests to speak to them.

2.6 We suspected that the kind of procedure we had decided to adopt would encourage some victims to speak to us who might not otherwise have done so. It would also enable all parties to speak more fully than they had been able to in the criminal court about what had happened and the circumstances that had allowed it to go on for so long without detection. This

suspicion was borne out by our subsequent discussions, especially with the victims, many of whom said they would not have wanted to subject themselves to further, formal questioning. Many also expressed their appreciation of an opportunity to speak more fully about their experiences and the lessons to be learned from them.

B. Practice (general description)

2.7 Having taken this position as our starting point, some further questions needed to be addressed:

1. How would we be able to comment on reports reputedly made in the past, if the source of the information about a particular report was a victim who did not come forward to talk to us?
2. How should we deal with cases involving allegations that had been found not proven or not guilty?
3. How much could we fairly say about conclusions that might be construed as critical of identifiable people if our enquiries had been conducted in the way which we adopted?

2.8 These questions will be addressed in turn in the next sections of this report.

a. Accessing Victims and Identifying “Reports Made”

2.9 In order to promote the ability of witnesses to speak about abuse, and in recognition of their potential embarrassment in doing so, the Court had been closed to the public whilst former residents gave evidence. The City of Edinburgh Council was refused permission to have an official observer during those sessions.

2.10 The trial however attracted a great deal of media publicity. Some of this recounted evidence that some of the former residents had tried as children to tell about the abuse, but that their reports had either not been responded to or had failed to reach an appropriate conclusion. Such “reports made” formed the central part of our remit with regard to the past.

2.11 The press statement issued by the Council following conclusion of the trial suggested that there had been two such “reports made” which appeared to have received no satisfactory response. These are reported here as Glenallan Reports 1 and 3. Subsequent correspondence with the Director of Social Work indicated that he had since learned of another report, which is set out here as Glenallan Report 2. The Director was also aware of three reports which had been subject to investigation at the time, the question for the Inquiry being whether the action taken at that time was appropriate. These are set out here as Dean House Reports 2, 7 and 10. We therefore embarked on this exercise with an indication that six reports might have been made prior to the investigation which led to the trial. We ourselves undertook an analysis of the daily press reports which produced further possibilities of reports having been made. We added these to the information we had received from the Director of Social Work and maintained this as a checklist against which to measure our progress during subsequent interviews with former residents.

2.12 We had to decide upon the most appropriate way of contacting those former residents who had given evidence. The addresses were held by the senior police officer who had conducted the extensive enquiry which had preceded the trial. He assisted us by

forwarding letters to the witnesses in which we spelled out our role and proposed method of inquiry and stressed how much we would value their assistance. We explained that our focus would be more about hearing how the abuse had taken place, and the attempts, if any, that they had made to tell of the abuse, rather than the abuse itself. We greatly appreciated the assistance of the police in supporting our request, which we believe contributed greatly to the fact that half of the former residents who had given evidence in the High Court trial accepted invitations to speak to us.

2.13 We made it a practice that at least two, and sometimes all three, of the Inquiry Team members met with each victim who responded. Where any expressed a wish to be interviewed only by the female members of the Team, this was acceded to. In addition, we spoke to a limited number of former residents who had not been named as victims and did not give evidence in court, but expressed a wish to meet us. We endeavoured to supplement the direct evidence of former residents by meeting with social work and nursing staff, some of whom had supported the young people during the trial and continued to have responsibilities for them.

2.14 Having concluded our interviews with those former residents, and correlated their reports to us with our checklist, we found that our list of possible “reports made” had increased from the six identified above to 18. Of these, we have been unable to follow up two to any great degree because the witnesses involved did not accept our invitation to speak to us. These were Clerwood Report 1 by Child J and Dean House Report 1 by Child M.

2.15 We had earlier considered how to take such matters forward. High Court proceedings require that a recording be made of all evidence led. We had thought we might be able to obtain a copy of that transcript. From enquiries with the Crown and Scottish Office we learned that such a possibility would be difficult, if not impossible to achieve. Because of the closed court provisions, permission would require to be granted by the Secretary of State. We were informed that it was by no means certain that this permission would be granted. Even if it were, since the tapes had not been transcribed, the Inquiry would have required to have paid for the whole work involved in obtaining transcripts. We were advised that the cost for each day’s evidence would be in the order of £500. Evidence had been given over 17 days. Looking to the delays, cost and limited value of transcripts, we decided not to press for them to be made available.

2.16 We did not pursue the issue of access to the transcripts of the High Court trial, therefore it would not be correct to say that we were refused access to them. However, we do believe that, as a matter of policy, such information should be made available to statutory enquiries such as ours, especially if it will spare the victims the experience of recounting their stories again. We would ask the Secretary of State to consider setting in place a policy and procedure that will make them more readily available to future inquiries.

2.17 An alternative approach was to obtain information from those Crown Office personnel involved in the trial. We liaised with officials from Crown Office and kept the Crown Agent informed of progress. Particular assistance was provided by the Depute Procurator Fiscal, David Dickson, who had prepared the case for trial, and Ms Fiona Davies, the Junior Counsel for the Crown during the trial. With the approval of Crown Office, Ms

Davies gave most generously of her time in drawing from her own extensive notes of evidence the details of that evidence and other information which it was proper for her to disclose to us. In addition to the actual evidence, she was able to provide valuable information on the way in which the young people had responded to the court processes, difficulties that they had experienced in this regard, and the support provided for them during the trial.

2.18 The files relating to the former residents' period in care were also clearly relevant to our remit. Voluminous productions had been uplifted from the Social Work Department and from Dean House and many of these had been used during the trial. We had to negotiate access to these files with the Crown Office in whose possession they remained, given that there was a possibility of further judicial proceedings. We experienced certain delays, because of the court process and the appeal by one of the accused, in seeing the productions which had been lodged in court, but eventually we were able to examine those held by the Procurator Fiscal and those held by the Justiciary Office pending the appeal. Many of the productions were case note files relating to the young people. The unavailability of the productions to the department has restricted their ability to carry out their own inquiry and detracted from the ability of certain members of staff in answering all our questions relating to events which took place a long time ago.

2.19 Our conclusions about reports made in the past are therefore based upon the evidence given to us by half of the former residents named in the indictment. Our ability to follow up "reports made" has been hampered by the failure of two of them to speak to us. Nevertheless, we feel we were right not to insist on their attendance. The trial was a harrowing experience for the victims, and we do not believe it would have been right to have subjected them to any more unwanted questioning. Where possible, we have tried to obtain information about these reports in other ways, and that approach has been reasonably successful.

b. Unproven Allegations

2.20 Since the criminal law recognises that it is preferable that 99 persons who are in fact guilty should be acquitted than one innocent person convicted, it follows that a substantial number of persons proclaimed "innocent" by the criminal law have actually committed the offences. If the same standard were to be applied in the civil law area of child protection, the innocence of the accused would be safeguarded at the expense of the innocence of children.

2.21 Within the children's hearing system, upon which we modelled our approach, action can be taken to protect a child on the basis of evidence established or accepted as true on the standard of the "balance of probabilities." This contrasts with the more rigorous standard applied to criminal cases where the facts have to be proved "beyond reasonable doubt." Further, criminal law requires all evidence to be corroborated. Civil law and child protection processes do not require this.

2.22 Of the 30 charges which went to the jury in respect of Knott and McLennan, guilt was established beyond reasonable doubt in 16. 10 were found to be "not proven." In only four charges was the verdict "not guilty." Both of the charges against the third accused (Michael Cull) were found "not proven." Two of the more serious charges against McLennan

were subsequently overturned by the Appeal Court on the basis that the abusive incidents alleged were too far apart in time to corroborate each other.

2.23 As our remit was concerned with the safety of children rather than matters of legal guilt or punishment, we felt we need not restrict our considerations to those cases in respect of which the court proceedings had resulted in guilty verdicts, but could take into account the reported experiences of other complainers.

2.24 Furthermore, as our investigations were focused on the making of reports rather than the actual fact of the abuse, we felt justified in making no distinction between the various reports on the basis of whether or not the criminal courts had found guilt to be established. Even if the reports made by children were not subsequently substantiated, they required some investigation and response. Our task was to ascertain whether there was a response and whether it was appropriate.

2.25 We considered whether conducting our investigations as we did might be interpreted as lacking “due process.” We would not want to be unfair to anyone, including those persons who were convicted of criminal offences, only one of whom, and he only to a limited extent, admitted any wrongdoing; nor to the third person who stood trial in respect of two charges which resulted in his being acquitted. We have however outlined earlier the method of obtaining information from witnesses who were not subjected to cross-examination. In any event, we have had to proceed on the basis that some abuse had been established, and so there was no need to attempt to re-run the trial with even the lower standard of proof, i.e., on the balance of probabilities.

2.26 That said, we believe we are entitled to draw inferences from the decisions of the jury. The most telling example is provided by the two most serious cases of which McLennan had originally been convicted, which were later overturned by the Appeal Court. In each of these cases the jury found it proved beyond reasonable doubt that McLennan had committed the offences, one at Clerwood and the other at Dean House. To do so, the jury must have believed each of the two women were telling the truth when they spoke of the abuse which had been perpetrated against them, and had no reasonable doubt in so deciding. The basis of the Appeal Court decision was that a substantial period of time had elapsed between the dates of the two offences, and because of that time lag, the two incidents could not corroborate each other. Had the time difference been shorter, that would have been possible. Corroboration is an element which must be established before a guilty verdict can be justified.

2.27 Civil evidence, which is the standard on which we operate, does not require corroboration. It seems reasonable for us therefore to accept the considered decision of the jury in that regard to these two charges. Further, there is a very clear difference between the standard of proof which applies in criminal, and civil cases. In civil proceedings, it is not necessary to establish matters beyond reasonable doubt, but only on the basis that it is more likely than not that what is alleged is true.

2.28 Given the two major variations we submit that it is reasonable for us, on the basis of the clear accounts given to us and other information to support these accounts, to accept the likelihood of the victim’s account of what they claimed.

2.29 At the risk of repetition, these decisions were taken on the beyond reasonable doubt standard of proof. We appreciate that not proven and not guilty verdicts both amount to acquittals. Nonetheless we submit that where the jury, whose decisions were described to the Court by McLennan's own Counsel in respect of him as "very discriminating" brought in only 3 not guilty decisions and 15 not proven decisions, that we are entitled to accept that that discrimination on that standard of proof entitles us to proceed on the basis that the nature and the gravity of the abuse which took place in these three homes was much greater than that demonstrated by the 16 original findings of guilt (later reduced to 14). Put another way, of 38 original charges in regard to the homes, 7 were withdrawn from the jury in respect of insufficient evidence and in only three of them did the jury in clear terms bring in not guilty decisions.

c. Drawing Conclusions

2.30 The third question to be addressed regarding our methodology concerned how much we could fairly say about conclusions that might be construed as critical of identifiable people if our enquiries had been conducted informally.

2.31 A feature of our investigations has been the willingness of those involved in past and present events to reflect critically on their own practice, and much of our comment builds upon that self-reflection. In the interests of natural justice, wherever it has seemed to us that a conclusion could be regarded as critical of an individual, we have intimated it in advance to that individual and invited a response. Where the response has seemed reasonable, we have amended our report to take account of it. Where we have, despite an indication of disagreement, decided to print material to which an objection has been made, we have referred to that objection within the report.

C. Accommodation and Staffing

2.32 A room was made available for the Inquiry within the Council Chambers on George IV Bridge, and most of our interviews were conducted there. It was also the location of the public hearings which took place in June, 1998, in partial discharge of that part of our remit which related to the present.

2.33 Secretarial assistance was provided by Mrs Gaye Duff and Mrs Debbie Harkness from the office of the Council Secretary at the City Chambers. They operated the confidential telephone line which we opened and responded efficiently and sensitively to many callers during the course of our work. At least one of us was in communication with them on a daily basis. Our sporadic, but at times heavy, demands for typing received immediate attention and were afforded priority over their normal work commitments. Additional administrative and organisational assistance was provided by Mr Alan McCartney, Senior Committee Clerk. During the period when we interviewed witnesses, and in the course of the public hearings, we and those who came to see us greatly benefited from the sympathetic understanding of the security and support staff who operated in the George IV Bridge building. We are indebted to all of them for their support and forbearance.

3. REMIT 1 – THE PAST

A. Text of remit

3.1 That part of the remit which related to the past required us:

1. In relation to the recent High Court case to ascertain if there was any allegation raised prior to the commencement of the police investigation, and if so –

to determine if there were any reports which were not acted upon and, if so, why;

to determine the appropriateness of action taken at that time;

to identify any lessons that may be learned against the background of what is known of practice and procedure in place at the time (i.e., 1973 – 1987), additional to what may be contained in subsequent reports in this field.

B. How information was gathered

3.2 In addition to interviews of former residents referred to at paragraph 2.12 above, we located and interviewed in connection with this part of our remit, former members of staff of the units involved in the abuse as well as former members of staff of the Social Work Department (some of whom remain in the employment of the department), and three former Governors of Dean House. The numbers interviewed are set out in Appendix 2.

3.3 We visited and interviewed one of the convicted abusers (Gordon Knott) in prison. We did not interview the other abuser (Brian McLennan) We believed it would have been improper and probably unhelpful to do so as, unlike Knott, he had never admitted any wrongdoing and had an appeal pending.

C. The facts of the High Court case

3.4 On 4 December, 1997, two former care workers were imprisoned for serious abuse of children in the care of Edinburgh Corporation and Lothian Regional Council between 1973 and 1987. Gordon Knott was sentenced to 16 years for crimes committed at Clerwood Children's Home from 1973 to 1977, and at Glenallan Children's Home and various holiday locations from 1978 to 1983. Brian McLennan was sentenced to 11 years for crimes committed at Clerwood Children's Home from 1977 to 1978 and at Dean House Children's Home from 1978 to 1986. Knott was also found guilty of possession of indecent photographs.

3.5 Clerwood and Glenallan were run by the local authority. Dean House was a voluntary home run by the Board of Governors of the Dean and Cauvin Trust, with children placed and paid for by the local authority.

3.6 The indictment included 22 charges against Knott. After evidence, five charges were withdrawn and 17 fell to be decided by the jury. He was found guilty of 11 charges (involving nine children). The jury brought in four verdicts of "not proven" and two of "not guilty."

3.7 There were 14 charges in respect of McLennan. 13 went to the jury. He was found guilty of five charges (involving four children). The jury brought in six "not proven" and two "not guilty" verdicts. McLennan appealed against two of the verdicts and against the length of the

sentence. On appeal, the conviction in respect of two charges was quashed and his sentence reduced from 11 to six years.

3.8 Initial charges had related to 27 children. Guilty verdicts were brought in respect of 13 of them, reduced to 12 after the appeal.

3.9 A third accused, Michael Cull, was acquitted of two charges relating to crimes alleged at Dean House. In respect of both charges, the jury brought in “not proven” verdicts.

3.10 A fourth person (a woman) was initially subject to two charges. Because of difficulties arising from witnesses’ attendance and their illness, the charges were dropped when the case was called. Although they were dropped on the basis that the woman could be re-indicted, it is our understanding that no further action will now take place in respect of her.

3.11 The trial began on 10 November 1997. The Crown listed 138 witnesses, although not all of these were actually required to give evidence. There were in excess of 200 productions. The verdicts were reached and sentences imposed on 4th December.

3.12 The events set out in the indictment make chilling reading. The following extracts all resulted in guilty verdicts. The human context of terror, humiliation and childish bewilderment will be addressed later in this report.

d. Gordon Knott

- *Boy age 5 to 9:* “on various occasions.... handle his private member, induce him to handle your private member and to masturbate you, induce him to take your private member into his mouth and to move his head back and forward until you ejaculated in his face.”
- *Girl age 4 to 8:* “on various occasions.... induce her to handle your private member, handle her private parts, kiss her chest and private parts and masturbate in her presence and ejaculate over her.”
- *Boy age 3 to 7:* “on various occasions handle his private member, insert your fingers into his hinder parts, induce him to remove his clothes, induce him to handle your private member and to masturbate you and attempt to penetrate his hinder parts with your private member and thus attempt to have unnatural carnal connection with him.”
- *Boy age 11 to 15:* “place your private member between his legs and simulate sexual intercourse with him, induce him to take your private member into his mouth, take his private member into your mouth, and attempt to penetrate his hinder parts with your private member and thus have unnatural connection with him.”

e. Brian McLennan

- *Girl age 14:* “on various occasions.... handle her upper body and private parts, expose your private member to her and masturbate in her presence, induce her to handle your private member and to masturbate you to ejaculation, insert your fingers into her private parts and into her hinder parts, induce her to take your private member into her mouth, insert a plastic instrument into her hinder parts and her private parts, insert a shower hose into her private parts and attempt to insert said shower hose into her hinder parts and place your private member between her legs and simulate sexual intercourse with her.
- *Girl age 11 to 17:* “on various occasions.... handle her chest and private parts, induce her to handle your private member and to masturbate you and place your private member between her legs and simulate sexual intercourse with her.”

D. Profiles of the Accused

a. Gordon Knott

3.13 This accused had admitted certain offences to the police. Because of that fact, we felt able to interview him in prison. It seemed appropriate to ask him questions about how he had managed to avoid detection for so long and offer him the opportunity, to which he willingly responded, to contribute to the Inquiry.

3.14 A native of Edinburgh, now aged 44, at the age of 19 he worked for a brief time as a voluntary worker in Manchester in a residential unit for older offenders. In 1973, he wrote to the Social Work Department in Edinburgh seeking employment as a social work assistant, with a view to qualifying as a field social worker. After interview, he was appointed to a post at Clerwood, designed as “nursery assistant.” In 1974, this designation was changed to “assistant house father.” In 1976 he became a house father. In November 1977 he was appointed as depute at Glenallan and in March 1979 appointed officer in charge there. When the unit closed in August 1985, he transferred to work with the elderly and remained in that post for some three years. Whilst at Glenallan he married a member of staff there. As a result of Council policy in relation to married persons working in the same unit, his wife required to resign, though for some time the couple continued to reside together at Glenallan. They had one child, but subsequently divorced.

3.15 While he accepted that he abused two children in Clerwood and three at Glenallan, he denied the extent alleged by the children and has continued to deny the other charges. He told the Inquiry that he had not chosen to work in residential child care because of the opportunities that career presented for sexual gratification through contact with children. Indeed residential care was not, according to him, his first choice of work. As a child, he had had one long standing homosexual relationship with someone of a similar age, but this fact had been known to no-one, including his own immediate family.

3.16 He said that he had enjoyed his first sexual experience with a young resident and that that had led him to repeat it. He had experienced no guilt or remorse. The only potential inhibitor was his fear of being caught. He pointed out that there was little professional awareness of the incidence of sexual abuse at that time. He was sure that none of his colleagues ever suspected any aberrant behaviour by him, and that, if they had, they would have spoken to him or reported the matter to his superiors.

b. Brian McLennan

3.17 As he had denied and continued to deny all the charges, we did not consider it appropriate to interview him. We did however correspond with Mrs McLennan who continues to support her husband's denial. She provided us with some written information from him which included the fact that he continued to deny all the allegations.

3.18 Now aged 52, he is married with one adult daughter. He left school at 15 with no qualifications, trained as a plumber and worked in manual occupations until 1971 when he and his wife emigrated to Australia. There he appeared to have worked with young people with learning difficulties; a field in which he claimed to have received some training. On returning to Scotland, he was appointed third in charge at Clerwood in 1976. Though he gave his Australian employers as referees and a request for a reference was sent to them by Lothian Region, no reply appeared to have been received. The following year he was appointed to the deputy's post in Clerwood. In 1978 he was appointed as officer in charge at Dean House, and retained that position until 1987, when he resigned. At that time he was suspended following a report commissioned by Lothian Regional Council into his management and alleged subsequent breaches of duty. None of the allegations which led to his suspension related to allegations of sexual impropriety. After leaving Dean House, he appears to have obtained employment working with people with learning difficulties in the North East of England, but returned to Edinburgh after a short time there. From 1989 until his imprisonment, he worked as a bus driver.

c. Michael Cull

3.19 We endeavoured to communicate with this man by writing to him at his last known address. The letter was returned by the postal authorities, marked "gone away." His solicitors informed us that, immediately after the trial, he had advised that he was "going away." He did not leave his solicitors with a forwarding address. We have therefore not been able to communicate with him in any way. Although he was acquitted in respect of the two charges brought against him, both of which alleged offences against early teenage boys, we propose to include information we gained in respect of the allegations made against him. Again,

reference is made to our responsibility not to restrict ourselves to those allegations in respect of which the jury brought in guilty verdicts.

3.20 From employment records it appeared that he had himself been in care from a very early age in a children's home in the Midlands of England, and only met his mother on one occasion. His reports about his time whilst in care indicate an unhappy childhood, during which he may himself have been the victim of abuse. Fostered at 11, he did not do well at school. He left school at 15, and at a young age obtained employment through community volunteers in hostel work in Dundee. Later, he worked for some time in a voluntary home in Edinburgh, replied to an advertisement regarding a vacancy at Dean House, and was appointed to the post, originally on a probationary period of three months. He had impressed his employers as being a willing, co-operative, if somewhat limited and immature, member of staff. To the police he consistently denied his involvement in the two offences. He elected not to give evidence during the trial.

E. Whether there were any Linking Factors

3.21 Although Gordon Knott and Brian McLennan worked together for a brief period in Clerwood, Knott denied that there was any "ring", and said that it was sheer coincidence that they had been working together. We found no indications to the contrary. Indeed, it seemed that they did not like one another. Two children claimed to have been abused by both Knott and McLennan at Clerwood, but we were unable to establish any link between the two separately alleged offences. Similarly, McLennan and Cull worked together at Dean House, with McLennan as the officer in charge. The indictment alleged that each of them committed offences in respect of the same child. The child told us that the offences were carried out at different times of the day. We gained no impression that the two named accused were acting in concert, or knew of the allegations made against the other. The woman originally charged in the indictment was alleged in respect of one charge to have acted along with Gordon Knott. That charge was withdrawn from the jury in respect of him. She was alleged to have been acting alone in respect of one other charge. We found no information which would allow us to conclude that there was concerted action. The police had been anxious to explore all possibilities that a "ring" existed. They did not discover any such evidence other than those matters to which we have referred, and we ourselves were given no information which would allow us to suggest that such concert existed.

F. Life in Care 1973 – 1987

3.22 The Inquiry's remit focuses upon reports made but not acted upon. We deemed it necessary to consider why other reports were not made at the time by residents or staff; how the abuse could continue for so long without detection, and generally do so against a background of what life was like for residents at these times in each of these homes, using as our base the description given to us by residents and staff from that time.

a. Clerwood

General Description

3.23 Clerwood was a rambling Victorian house situated at the top of Corstorphine Hill. It was run by the local authority and could accommodate 24 - 30 children, from babies up to the age of 15 or 16. In accordance with the pattern of child care at that time, many very young children were accommodated in children's homes. The alternative of foster care was much less developed than it is now. When a new officer in charge was appointed in 1976, he found it was in effect an extended nursery. He recalls that when he arrived there was a "matronly" feel about the building with "brasses well polished" and a very hierarchical management structure. The staff complement still included a post of "Matron's maid." He remembers cots being there and his determination to get rid of them, which he had effectively done by the time Clerwood closed in 1982. Knott's first appointment was as a "nursery assistant."

3.24 The officer in charge was only 25 years old when appointed to this post, having obtained a certificate in residential child care two years previously. For the first year and a half, he lived in the main building, latterly with his new wife, who was in different employment. They then moved into a cottage in the grounds a few hundred yards from the house.

3.25 Knott and McLennan were already in post at Clerwood when the new officer in charge arrived. McLennan was officially Third in Charge, but had run the home when there had been no officer in charge or depute in post. The officer in charge believes McLennan did not take kindly to his arrival as the boss, with new ideas, and says they clashed on occasions. He claims McLennan had an institutionalised approach to child care, that he focused on control and shouted at the children. Sometimes he went drinking and clearly had been drinking before coming on duty. Nevertheless, the officer in charge gave McLennan a reference for his subsequent post as officer in charge at Dean House, two years after the officer in charge's arrival. He claims to have mentioned in the reference that he had certain concerns about McLennan but felt that, as a manager, these defects would not seriously detract from his ability to manage a unit. The then officer in charge accepts now that that approach was perhaps naïve and puts it down to his inexperience at the time. It was suggested to us by a number of individuals that it was not unknown at that time for references to be used as a convenient method of arranging that unsatisfactory employees be deployed elsewhere. We have been unable to draw such an inference in respect of this reference, but cannot accept that a person who had demonstrated an authoritarian approach and a tendency to indulge in alcohol when in a junior position would be less likely to demonstrate these failings as an officer in charge, particularly in the light of the then traditionally unaccountable "godlike" figure and culture attached to the officer in charge posts.

3.26 Gordon Knott had commenced employment at Clerwood just shortly before the new officer in charge's appointment. They quickly became friends. Not all staff liked the changes the new officer in charge was trying to introduce. Some clung to the nursery culture. Knott favoured the new approaches and development and this may have helped strengthen the bond between the two of them.

3.27 On occasions, Knott stayed overnight in the cottage, or was there when the officer in charge and his wife were both at work. There were suggestions that some of the abuse by Knott took place in the cottage, but the officer in charge and his wife said that children did not visit and they had no reason to suspect it had been used for that purpose. The officer in charge's wife recalls Knott as a nice, genuine, caring guy. Their friendship with Knott (and later his wife), continued after Knott left Clerwood for Glenallan and Knott continued to visit them at Clerwood. When the officer in charge left Clerwood he moved into a position which also involved further professional contact with Knott.

The Children's Perspective

3.28 Child A was 18 months old when placed in Clerwood in 1971. She remained until 1977. She remembers Clerwood as "a place of misery." She recalls standing in her cot crying, for what appeared hours, but "nobody came." She claims Knott began abusing her at an early age, and believes other staff must have known. In support of that belief she cites the fact that no questions appear to have been asked about Knott, a young man of 20 or 21, taking her on her own to the Botanic Gardens or to his own home, sometimes driving back late at night. Knott denies that he did so, and in fact insists that he did not own a car during his time at Clerwood.

3.29 Child B was one of a family of four placed at Clerwood. She was there from about 1971 to 1978 when she was aged 3 to 10. She maintains that she began to be abused from such a young age that she did not know it was wrong. She did not discuss it with anyone – not even her own brother who was also resident there. She says she did mention it in general terms to another child. She began to realise it was wrong when later foster carers warned her about her inappropriate sexualised behaviour. However no questions were asked about where she had learned that behaviour. In her new placement she was waiting for the abuse to happen and was puzzled when it didn't. She thought she must have done something wrong.

3.30 Child B felt that other staff must have known what was going on at Clerwood because they often came in and out of rooms and would "stay out of the road" when things were happening to her. She was worried that if she said anything she would be "put away and never see her family again." Once when she said she would tell, she was threatened with her brothers being moved. Two days later they were moved. As she was given no explanation, she interpreted it as the threat coming true. She was also dissuaded from telling by threats and physical punishments. She did feel closer to a couple of staff, but says she was never alone with them. Even if she had had the chance, she might not have told because to do so would have been "too risky."

<p>Lesson 1: It sometimes seemed to the children that other staff must have known what was going on.</p>

3.31 Child C (Child B's brother), also placed in Clerwood at a young age, echoes many of his sister's observations. He was so young when it started that he did not know it was wrong. He never discussed it with the other children. He was later moved to a happier children's home where he felt more secure, but it never occurred to him to tell what had happened to him. Even if he knew by then that it was wrong, he thinks he would have put it to

the back of his mind. If he had made a fuss about the abuse, he feels he would have been seen as a trouble maker and possibly sent to an assessment centre. He didn't think anyone would have cared anyway. Parental contact for B and C was extremely limited.

3.32 Child D (Child A's brother) was aged between 5 and 9 when abused by Knott at Clerwood. Like many of the others, he did not understand at first that he was being abused. He recalls feeling very isolated, although he shared a dormitory with at least 10 beds. Knott befriended him and made him feel special. He "loved Knott like a dad." He recalls Knott being apart from the other members of staff.

3.33 He told us of numerous subsequent units and foster placements after he left Clerwood, aged 7. Such files as we have seen confirm his recollection. Further, they clearly show that he demonstrated worrying behaviour and overt, inappropriate sexualised behaviour at that time. These matters were recognised and commented on by social work, medical and psychological personnel who were concerned as to how to address his disturbed behaviour. However, no suspicions appear to have been raised that he may have been the victim of abuse.

Lesson 2: Some children were so young when the abuse started that they did not realise it was wrong.

3.34 There was a member of staff Child D liked but, when he began to understand the abuse was wrong, he did not consider telling him about it. He had lost all trust in staff because it seemed to him that they must have known about the abuse and didn't help. Neither did he feel able to tell staff at the school the children attended not far from the home, basically because he trusted no-one. The father of children A and D was in prison. Their mother had very little contact with them

3.35 Child E was aged between 7 and 14 when in Clerwood and claims to have been abused by both Knott and McLennan. She described Knott as a mixture of arrogance, confidence and friendliness. He was more approachable than McLennan and carried out his behaviour in a "nicer way" than McLennan. She said McLennan was a bully and was always "watching children."

3.36 Child E recalls the children climbing a tree outside the staff room window and shouting "Brian's a perv." She thinks they hoped someone would take notice, but nobody did. Staff just told them to come down and behave themselves. She said that children also ran away constantly but no-one - staff or children's hearing - ever asked why. Despite these indications of acting together or in similar ways designed to draw attention to the abuse or to escape from it, it seems the children did not talk amongst themselves about the abuse or what they were running from.

Lesson 3: The children did not generally discuss the abuse with each other. It was experienced as a private matter. However, there was often a common, unarticulated understanding which manifested in group activity such as name-calling and repeated patterns of behaviour. Adults did not pick up these signs.

3.37 She too had siblings in the home. Ironically, though their reception into care was attributed to their mother's alcoholism, according to Child E, staff frequently sat around the Unit "drinking Carlsberg." The quality of the mother's contact with the children and their ability to confide in her was limited by her addiction to alcohol.

3.38 Child E liked one of her field social workers very much but still felt unable to tell what was going on.

3.39 Sexual abuse was not the only issue at Clerwood. Some of the former residents talked about being forced to eat food out of "the trough" if they misbehaved. The trough contained a mixture of all kinds of food and ingredients. If they didn't eat it, their heads and faces were pushed into the food on the trays. One former resident also recalled being beaten with a stick and dog leash by a member of staff. He was angrier about that than about the sexual abuse. The Director of Social Work at that time informed us that a member of staff had been sacked for that kind of behaviour. McLennan claims to have brought that about.

3.40 The following comments from children living in Clerwood at that time exemplify their recollections:

"Social services screwed my life up from day one. I feel let down, pissed off and bloody angry at the way I was treated. Management should have got off their arses and looked at what was going on."

"When you're in care when you're wee you dinna trust anybody because you know you've got to go back."

"You've got to cover yourself when you're in homes. Because if you speak out about a staff member and they are next on duty – you've got to watch yourself."

"When you're taken from a violent family and put into a home and the same thing happens, it just becomes a routine and you get used to it."

"Young people would rather run away and get glued, because if they say anything they might get sent somewhere worse."

b. Glenallan

General Description

3.41 Glenallan was a modern, purpose built building situated in a nice neighbourhood. It was run by the local authority and accommodated 12 children, mostly in family groups of three or four. The term "family group home" was coined at that time to recognise that the authority required to receive into care brothers and sisters from the same family and the need to maintain the value of family links for them. At the time of the abuse, the ages ranged from about 5 to 13. Three of the children (including two who were related) had special needs. Some of the families had no real outside links with their parents or extended family. In the most obvious example, the father of one group of children was in prison for murdering their mother.

3.42 There was rarely trouble in the Unit. Glenallan was considered at the time to be a peaceful, stable unit with relaxed, quality standards of care, and one which was accepted by the local community, though some former residents felt that their neighbours neither

understood nor approved of the creation of a children's home in the area. The community policeman was a regular visitor who used to read stories to the children. He appeared to be friendly with Knott when he was officer in charge.

3.43 Knott had originally been appointed as depute in 1977. In 1979, he was appointed Officer in Charge and remained such until the Unit closed in 1985. His immediate predecessor in that post had resigned to advance her studies. She was a religious person who believed in standards and discipline, but also stressed the value of close relationships. Many staff and some former residents spoke warmly of her, although one former resident was exceedingly unhappy about her own relationship with her.

The Staff Perspective

3.44 A junior member of staff who spoke to us had gone to work in Glenallan as a care officer in 1978 at the age of 18 and with no qualifications. She explained how easy it was to get a job in residential care on a permanent or temporary basis: "If you came along and you were willing to do a shift, you got across the threshold." She chose to work in Glenallan because it felt more homely than other units she had visited. It felt safe and caring. Gordon Knott was at that time the depute.

Lesson 4: Recruitment practices were poor. Staff were often young, untrained and inexperienced.

3.45 Another staff member was 25 when he went to work in Glenallan, initially as a temporary worker, in 1979 when Knott was in charge. This staff member had no qualifications. Nevertheless, he was soon taken on permanently and became third in charge. He described Glenallan as initially a great place to work. He had worked in other family group homes which were very regimented and where children were forced to call carers Auntie and Uncle and got fined for things like swearing. Glenallan was more relaxed. Nice things happened, like the occasion they adopted a lot of kittens.

Lesson 5: To the outside world, Glenallan had the appearance of a happy and successful establishment.

3.46 The staff were aware that Knott had one particular favourite amongst the children (Child G). There was a lot of physical contact between the staff and children. Practices which nowadays would ring alarm bells did not do so at the time. A description was given of how, at weekends, staff and children sat up late to watch television. The lights were put out and Knott and his favourite would cuddle and hug on the sofa. At the end of the film, Knott would take the child upstairs for a bath. The boy was 12 years old at the time. Soon after the Knotts' marriage, the unit, including the officer in charge and his newly acquired wife, went to France on holiday. Staff were embarrassed at the extent of Knott's closeness of contact with the boy who appeared to be vying with Mrs Knott for her husband's affection.

3.47 Knott accepted to us that he had had a "favourite" amongst the children, but countered that by saying that other staff had favourites too, although he did not suggest that, with them, there was any suspicion of associated abusive behaviour.

3.48 From the staff's point of view, the situation at Glenallan gradually deteriorated due to Knott's lack of management skills. The children were getting more out of control. Knott was not prepared to address the issues. His priority was that the children should like him. Staff meetings were a farce and the staff developed into little cliques. Staff say they raised limited concerns directly with Knott, but their efforts in this regard, which they apparently did not raise with his line manager or the unit's allocated Adviser, brought no improvement. Knott has no recollection of any serious internal staff criticism. The managers believed Knott was operating effectively and were impressed with the relaxed atmosphere within the home which they attributed to his leadership style. The Adviser did worry that Knott was working too hard and not taking appropriate leave breaks. He had to instruct him to take a holiday.

The Children's Perspective

3.49 The family of Child G consisted of 7 girls and two boys. Three of them were in Glenallan. G, who had experienced various placements before being placed at Glenallan in 1976, told us:

"I loved Glenallan at first because I was used to being in a house with no electricity, food or heat. [The former officer in charge] was great. She was religious and strict, but not abusively so. She made us say prayers before meals and going to bed. When she moved Gordon [Knott] got the job as officer in charge. At first I thought he was a great guy. He lifted the rules. There were no more prayers and we could have sugar puffs instead of porridge."

3.50 His sister, Child L, who claimed to have had a bad relationship with the previous officer in charge, described Knott's arrival as "like a ray of sunshine." He tore up the rulebook, decorated the home and gave them more pocket money.

3.51 Child H lived there for seven years, from the age of five. He resented his mother and her abuse of alcohol. He and his younger brother felt safe at Glenallan. He did not wish to leave, but was persuaded to allow himself to be adopted. That adoption was not a success. Long after the child had left care, he wrote a book describing his life in care. He had been encouraged to do so by a Barnardo's worker. Copies were lodged in court as productions. A whole chapter is devoted to the time he and his brother were in Glenallan. The chapter about Glenallan and what he told us confirms other accounts of that home and the successive officers in charge. He writes and speaks warmly of the officer in charge who preceded Knott, despite his view of her concentration on matters religious. He welcomed the arrival of Knott who he originally liked, but later resented.

3.52 The fact that Glenallan was experienced by the children as a caring place was one of the factors which stopped them from telling about the abuse. They did not want to upset things by telling. If they were believed, they would then feel responsible for the consequences, which might include Glenallan being split up, and a lot of people being made unhappy. If they were not believed, they might be punished by being sent somewhere worse, possibly an assessment centre. One former resident said staff created fear about the assessment centre. They said it was a bad place for bad people. You got locked up and it was full of smokers and glue-sniffers.

Lesson 6: The fact that Glenallan was experienced by the children as basically a caring place made the threat of moving somewhere worse, especially an assessment centre, a powerful inhibitor against telling of the abuse.

Lesson 7: Many of the desirable qualities of residential care staff in terms of empathy with children can also be a screen for abuse.

Lesson 8: Because Glenallan was basically a good place to be, children feared making others unhappy if their reports of abuse led to the home being closed down.

Lesson 9: The children feared being split up from siblings. The threat of this stopped them from telling of the abuse.

Lesson 10: Children's most tender feelings were exploited to keep the abuse a secret.

Lesson 11: Glenallan Staff were unable to communicate their concerns effectively to the external managers.

Lesson 12: External managers did not recognise that there were serious problems in Glenallan.

3.53 We were told how staff rotas and sleeping arrangements facilitated the abuse. Because of staff shortages, Knott did lots of shifts and encouraged other staff to go off early. Sleepover staff were reduced in number from two to one. Knott insists that the employment of night staff meant that he was not alone on duty.

3.54 Child G and his sister, L, who was described as being protective of him, felt they were split up physically and emotionally. Physically, their rooms were moved to opposite ends of the building. Emotionally, they were encouraged to fight with each other, when Knott would take the boy's side and then send the girl to bed as a punishment.

3.55 As explained to us, emotional manipulation appeared to be a relevant factor. G said the abuse started a week after his mother was murdered by his father. He told the Inquiry: "Gordon said he would be like a Dad to me. I was very upset because my Dad was in Jail. Gordon was like a father figure. I didn't think there was anything wrong because Gordon told me it wasn't wrong. ... Sometimes I was scared..... He didn't force me to do anything, but if I said No he went into a huff and made me feel sorry for him." Knott describes this as a total fabrication.

3.56 He also told us that a teacher had spoken to him regarding a down-turn in his work and asked whether anything was wrong. His enquiries were persistent, but G was afraid that, if he told him the reason, i.e., the abuse, it would get back to Knott.

c. Dean House

General Description

3.57 Dean House was a large, detached house in a highly sought-after and expensive residential area. It accommodated about 10 children from age 5 up. It was run by the Dean Orphanage and Cauvin's Trust, a voluntary charitable organisation with a long history of charitable work in Edinburgh, stretching back to the eighteenth century. Its purpose was to

provide homes for children in or near Edinburgh. Historically the Trust had been involved in running large institutions. From that it moved to develop smaller family group homes. The Trust operated through a Board of Governors and a House Committee.

3.58 Brian McLennan was appointed to the post of officer in charge in 1978. The Chair of the House Committee at the time recalled that he seemed eminently suitable. He was a young parent with a young baby and good references from Clerwood.

3.59 McLennan's period of employment coincided with a time in which Dean House was in the process of transition from a home that would look after needy children to a residential resource for children who needed a high degree of professional help. This involved a professionalisation of staff and a consequent distancing of the Governors from involvement in decisions about children. The Board minutes show that much energy was expended on considering how to respond to the challenges presented by the changing context of residential care.

3.60 In 1984, the minutes show that Governors and staff were also concerned about the home's viability and job security because of a low occupancy rate. A former Chair of the Board told us that they had felt a pressing need to bring in more children. The organisation was therefore very pleased at receiving one family of five children. A social worker who acted as a link between Dean House and the local authority described McLennan going to the "meat market"; a meeting held by the social work department where children were allocated to homes. He described how, when McLennan emerged from the meeting with an additional resident, this was seen as a means of keeping the organisation going.

Lesson 13: There is a danger of decisions about placements being inappropriately influenced by the need for independent organisations to maintain an income flow.

3.61 Brian McLennan lived in a cottage in the grounds of Dean House. To the children it seemed that he was very much "in charge." He was "the boss" and they were not aware of anyone having authority over him. One social worker with responsibility for a number of children there, indicated that that "autocratic" approach, which he found obtained there, was very much "par for the course" by the officers in charge at the time. The expectation of the local authority was that officers in charge would really be "in charge."

Lesson 14: The children in Dean House were not aware of McLennan having a boss.

3.62 Nevertheless, it would seem that McLennan took even more upon himself than would have been expected at that time. In theory, the children were allocated "key workers" who took special responsibility for them. One might have expected this to include writing reports for reviews and children's hearings and attending with the child. In fact the key worker system existed in name only. McLennan wrote the reports and attended hearings with the children, though on occasions he was accompanied by another staff member.

Lesson 15: At Dean House, the key worker system seems to have existed in name only. McLennan was in effect key worker for all the children. He wrote the reports and attended children's hearings with them. It is dangerous to allow too much power to be concentrated in the hands of one person.

3.63 The staff comprised four females and two males, including the officer in charge. Staff worked three shifts and, as there were only two workers per shift, both had to help bathing the children. Gender considerations were not taken into account.

Lesson 16: At Dean House, bath time was the occasion of much of the abuse. Staffing levels meant that workers were alone with children. Gender considerations were not taken into account.

3.64 In his letter to us, McLennan said parents were encouraged to visit Dean House and discuss issues with staff. Children had the opportunity to speak to parents and discuss problems. This contrasted with the experience of Clerwood where he recalled only three parents visiting during his time in that unit.

The Children's Perspective

3.65 According to the former residents, McLennan gave the children the impression that they were there on his sufferance and that he had authority to have them moved. This was a powerful threat as, apart from the abuse, Dean House was a more pleasant environment than many other homes. Many of the children had been in earlier placements elsewhere. Child N, who entered Dean House in 1980, aged nine, said to us that she loved being there until the night the abuse started.

3.66 Child R was aged 14 when given a choice of Units to enter in 1986. She chose Dean House because it seemed homely. It was a big house with ordinary furniture. She was allowed to choose how her room would be decorated. Her general experience of Dean House seemed to be less happy than that of Child N. She said that, if McLennan had had a bad day, he would take it out on the young people, chasing them to bed for no obvious reason. He made demeaning comments about them and made them feel small. He “gave them the third degree” when they asked for pocket money to go out.

3.67 She also reported a degree of sexual harassment running throughout McLennan's contact with the children. She said he “seemed to get a kick” out of the fact that girls had to ask him for sanitary towels or deodorant. They would go in twos to ask rather than be alone with him. According to her, he was in the habit of smacking girls' backsides as they went up the stairs. This was never challenged. Sometimes he came into the girls' room, and once when she was ill he put his hand under the covers and patted her leg. She felt unsafe at night. She was often the only young woman in the unit as her roommate had home leave at weekends. The female member of staff who was on duty slept in the independent living unit. The layout of the building meant it would have been impossible for anyone to hear noise or shouts.

3.68 She remembers that a lot of the young people made sarcastic comments about McLennan and called him “Pervy Brian.” She did not know why they this until he assaulted her. After that, she talked to the other girls about it in an indirect way but was reluctant to talk about the abuse to which she had been subjected. She simply joined in with the comments the others made.

3.69 She didn't know if other staff members were aware of what was going on. She felt they hated McLennan. She knows staff heard the comments about “Pervy Brian,” but other

young people sometimes called residential workers "poof" and this was seen as something they did when they fell out with people.

3.70 She recalled that McLennan always smelled of drink, and said it was common knowledge amongst the young people that he had alcohol delivered with the food order.

3.71 For many of the youngsters, the use of alcohol featured in the grounds of referral alleging parental inability to care for them and leading to their placements in residential units. It was also a recurring theme during McLennan's time at Clerwood and Dean House. Child Q reported that McLennan used to take them to football matches. He would stop at the pub for a drink, leaving the young people in the car. Then he would drive them to the match while at least to some extent, under the influence of alcohol. Certainly, he smelled of it. Another former resident spoke of her pleasure in demolishing a pyramid of beer cans which staff had built up in their quarters.

3.72 Some residents recalled incidents of self harm. Child R said she once deliberately cut her wrists with a piece of plastic. Instead of helping and understanding, McLennan showed her how to "do it right." It seemed that no children were directly asked as to the reasons for any self harm.

3.73 One long term resident, Child Q, claims to have been abused over the period from the age of 10 to 15, and that he was abused separately by McLennan and the accused who was acquitted. He had learning difficulties. He attended a special school and was often about the house when the other residents were not in. He said: "Brian would do the nightshift. I used to share a room with the other lads. Then I got my own room. He used to creep up at night. The wood squeaked. He took me upstairs. This happened almost every night. He said not to tell. Sometimes he was nice. Sometimes he was nasty." He said the abuse perpetrated by the other staff member took place during the day. As a child attending a special school, he returned to the home from school earlier than the other residents.

3.74 He had a very clear recollection of one such occasion when somebody knocked on the door and of himself panicking. It was "time to leave" and he went out by a back stair to the garden so that he could get away more quickly and nobody would know. "I was really scared; like feet nailed to the floor." His reaction typified reactions of abused children in inappropriately accepting that somehow he was to blame.

3.75 Because such a significant number of Dean House residents responded positively to our requests to meet them, we were able to consider the issue of whether the children tried to tell about the abuse they were suffering. If they did not try, why not? This report will go on to consider some specific instances in which children did try to tell. However, the thinking of Child Q was well illustrated in his interview with the Inquiry. When asked whether he told anybody about the abuse. He replied:

1. I told classmates at [school]. They didn't believe me.
2. I told a teacher at [school]. She said "Don't be silly. Go out and shut the door."
3. I never told [his social worker - now retired]. She did ask me if I was all right but I don't think I could have talked to her about things like that, although she was nice and I liked her. I didn't want to think about it.

4. I could not have told my foster parents [where he went on leaving Dean House]. They were older. The old man was OK but I didn't like the woman much.
5. I couldn't tell my mum. Anyway, I didn't see much of her.
6. I couldn't tell my sister. She was in care with me in Dean House for a little while. She went to different foster parents.
7. I couldn't have told the police officer who was married to somebody in Dean House. He was a nice bloke and wore a uniform, but I wasn't going to tell him.
8. After I had been at [school], I went to another special school. I couldn't have told any of the staff there about what had happened.

3.76 Social workers are generally regarded as an external check on the care children are receiving. They are part of a fieldwork team and do not work from the residential unit. There are questions about the extent to which their contact with the children allowed them to develop a relationship with the children in care, both in terms of frequency and substance.

Lesson 17: At Dean House, the children did not experience contact with field social workers as a safeguard.

3.77 There are differences of opinion about the extent of the contact the Dean House children had with their own social workers. Brian McLennan's written statement to the Inquiry claimed that they were visited regularly - at least once every two weeks - when they were either taken out or given the privacy of a room at Dean House. The children did not recall visits by social workers as significant.

3.78 Where social workers did figure in the children's memories, the children generally said, like the boy quoted above, that they would not have considered telling them about the abuse. They regarded all of the adults involved as part of the system which was abusing them and did not trust any of them. They also thought that they would not be believed.

3.79 Neither did those who were subject to supervision requirements feel able to tell children's hearings. McLennan attended with them and, according to one former resident, coached them about what to say.

Lesson 18: Children at Dean House did not experience children's hearings as a safeguard, as McLennan went with them.

3.80 Child R reported that, even if there had been an independent person, she is not sure she would have told because she would still have felt that she would not have been believed. When you were in care, you were labelled and it was assumed you were bad. Had she still been attending the school she used to go to before going into care, she might have told someone there because they knew her better and would have been more likely to believe her. When first contacted by the police she had denied the abuse. What helped her to speak out later was the knowledge that others were also doing so.

Lesson 19: At Dean House an inhibiting factor was that children felt stigmatised by being in care, and did not feel they would be believed about the abuse. Staff later conceded that, at that time, they did not believe such allegations as were made.

The Social Worker's Perspective

3.81 The pleasant appearance of Dean House was confirmed by a local authority social worker charged with the supervision of one of the children there. She told the Inquiry she was in contact with the child every three weeks. There was “a nice feel about the place. I never felt alarmed. The atmosphere was warm. The grounds were spacious. There was a tree from which the kids used to go swinging. I often went there and had tea with [Child P] and with the staff. I was made to feel very welcome.”

Lesson 20: Dean House seemed to be a happy place.

3.82 The children at Dean House had said that one reason why they did not tell their social workers was that they felt they would not have been believed. Sadly, this insight seems to have been borne out by their subsequent experience. Two social workers involved in the reports children did make, which are further discussed below, told the Inquiry that they did not at the time believe the children's stories.

The Dean House Staff Perspective

3.83 Staff of the home itself seem also, in retrospect, to recognise the difficulties children experienced in telling about the abuse. One said that, looking back, she felt there was little likelihood that young people would have felt able to disclose to staff. Awareness, training and practice had moved on a lot since that time. At the time she was the only qualified social worker at Dean House. She was led to believe that McLennan had some nursing qualification from Australia, but that may have been with adults rather than with children. Although there was a hierarchy of staff in the home all, apart from McLennan, really worked on the same level.

Lesson 21: There was little awareness at the time that adults could indulge in sexually abusive behaviour. This lack of awareness, and difficulties in articulating and raising issues, would have made it all the more difficult for children to talk about abuse.

3.84 A staff member described McLennan as a competent administrator. There was a recognition that he was a drinker, but his lunchtime drinking did not seem out of the ordinary and did not seem to have much impact on his work.

3.85 The former depute officer in charge indicated that the home also had independent, external links. She spoke about a “league of volunteers” who visited the home. They were mostly local, well-to-do women. Some of these volunteers helped the children with their homework and provided practical support for improving residents' academic abilities and interests.

Lesson 22: Dean House staff and Governors find it difficult to understand how abuse could have taken place, when there were so many volunteers visiting the house. Visits by community policemen were a feature at both Dean House and Glenallan.

3.86 The Governors were experienced by the staff as quite distant though they did recall one longstanding Chairman visiting on a regular basis. McLennan was seen as the only staff

member to have direct contact with the Governors. The Depute from 1980 indicated that her own contact with the Board was limited to occasions when McLennan was on holiday. Even then, her impression was that the Governors would prefer to postpone action and meetings till his return.

Lesson 23: Staff at Dean House experienced the Governors as distant. They said that their attempts to tell about their concerns were not responded to. This raises the question of the appropriateness of the backgrounds of those running independent organisations in relation to the expectations now made of them.

3.87 Staff became disenchanted with McLennan's style of management. For a long time, staff remained static and accepting of the status quo. When new staff members were recruited, they attempted to raise their concerns with the Governors, but claim they were not always able to do so. Subsequently, a number of them wrote to the Director of Social Work. This is discussed later in this report as Dean House Report 10.

3.88 The Assistant Principal Officer who was the local authority's link with Dean House, told us that he had noticed a distinct schism between a large number of staff and McLennan, and a lack of communication with the Governors who he described as august people who had little understanding of residential care.

The Governors' Perspective

3.89 The picture represented to us by the children and staff of life at Dean House differs considerably from that of the former Governors we interviewed. Far from being a remote and inaccessible body, they reported frequent visits to the house. One, who lived nearby, made regular, unannounced visits.

3.90 The Governors also reported that there was involvement by people from the local community. In addition, House Committee members used sometimes to mingle with the children after meetings in Dean House, although the children were often "glued to the television" and did not appear to be very interested. There had also been Christmas parties attended by some of the Governors at which they had been introduced. They found it difficult to understand how children could have been unaware of the identity at least of the House Committee members.

3.91 The allegations of abuse had come as a complete shock. As far as the Governors were concerned, the children had shown no signs of being disturbed. They find it difficult to understand how the abuse could have gone on for so long without any external signs which could have been picked up. Some of them still have difficulty in believing it. As one longstanding Chair said, "We thought we were running a jolly good show." Another former Governor reported that he was now more aware from subsequent cases in which he had been professionally involved, that sexual abuse is much more prevalent than was previously recognised and, such as within families, can go on for a long time without being detected. At the time, nobody believed that people like McLennan would "finger" little girls as he was accused of having done.

3.92 Another former Chair of both the House Committee and the Board, experiences similar difficulty in coming to terms with the fact that abuse had taken place. She reported that the staff were “at loggerheads” and did not like McLennan. Had they suspected abuse she was sure they would have reported it and used it as a way of “seeing him off.” She also reported frequent visits by the community policeman.

3.93 The Governors did report that there had been two allegations made in 1981 and 1982 against McLennan and Cull respectively. These are considered in detail later in this report as Dean House Reports 2 and 7.

3.94 There had also been suspicions about McLennan’s drinking, brought to the Governors’ attention by staff. This was subsequently investigated by the Social Work Department and occurred shortly before he left Dean House. This matter is also considered in greater detail later in this report as Dean House Report 10.

3.95 The former Governors reported feeling a deep sense of betrayal at McLennan’s abuse of the children entrusted to his care. Many of the children from all three homes reported that they feel betrayed by everyone.

3.96 McLennan’s successor as officer in charge at Dean House took up post in April, 1988, five months after McLennan’s resignation. A qualified social worker, she was concerned at what she found at Dean House. There were no procedures and no recording. Only one member of staff was qualified. She was not told in a direct way why McLennan had left. Neither was she told about the 1982 allegations against Michael Cull, who was still in post. She did not have access to previous minutes or personnel files which were kept at the Board Secretary’s office in the city. The new officer in charge set about remedying these defects with the co-operation of the Board.

3.97 The following are some comments from children living in Dean House at that time.

3.98 Child S spoke about attending meetings of various sorts convened to discuss her:

“It’s like being a plant in the centre of a table and people are all sitting around it and talking about the plant.”

3.99 She added that it would have helped if she had actually been asked to contribute her opinion. The following two observations were made by Child P:

“Brian was the boss. I couldn’t tell the boss. I wasn’t aware of anyone being his boss. Can’t remember having a social worker. They don’t believe you anyway, so where’s the point? Couldn’t have told the panel. They think you’ve been put in a home because you’re bad. But you’re not. You’ve been put in care to get looked after.”

“Mick would be nice to me. I trusted him like a dad. The children didn’t talk to each other about it. It was private. Also, I was young. I didn’t think it was wrong.”

Lesson 24: At Dean House, people designated as second and third in command were really working as care workers with no supervisory responsibility and nominal key worker roles. It seems astonishing that they did not question the fact that they were being de-skilled and not allowed to carry out their functions.

d. Management of the Homes

3.100 The Director of Social Work for the latter part of the period covered by the abuse (1979 to 1986) described to us how he had come to the post from a background in residential care and had been committed to improving standards. For this purpose, he had been given a sum of money by the Council. He had use it to set up a system of external advisers to the residential units, involving Assistant Principal Officers, known as APOs.

3.101 His observations regarding the Department he inherited demonstrated the split between Residential & Day Care and Field Work. Each of these Assistant Directors wielded real power. They operated independently of their counterpart. Many practitioners spoke adversely of this split to us.

3.102 The Assistant Director of Residential & Day Care from August 1982 until April 1991 agreed that there was a feeling at the time that Residential & Day Care and Field Work were “two different empires”. He himself had a background in field work and was committed to changing this perception. The impact of the split upon residents would arise from tensions between the residential staff and field workers, who were generally better qualified. There would be disagreements about receptions into particular units and about the extent to which field workers met their commitments to visit children.

Lesson 25: Within the Social Work Department at that time there was a lot of autonomy at all levels.

Glenallan and Clerwood

3.103 Management of the units was the responsibility of the Assistant Director, Residential & Day Care Section. The period covered by the abuse was one in which there was a development of line management of the units by external managers. In the earlier part of that period, external management was less sophisticated. There were external “Advisers” whose role was not well defined. When the APOs were introduced, unit managers became accountable to them. They were themselves accountable to the Depute Director/Principal Officer for Children. The APO’s role continued for a time alongside the Advisers who held responsibilities for a number of units. Eventually the “Adviser” role was felt to be superfluous and was phased out, with many of them being promoted to APO as vacancies arose.

3.104 Part of the Adviser’s remit was to provide consultation to and direct supervision of the officers in charge of his allocated Units. According to Knott, both Adviser and APO were “splendid”. Unlike some others in their position, they sat down and talked with the children. Knott believed that, if either of them had had any inkling of how he was acting, they would have taken the appropriate action immediately. One Adviser told us that some of his visits were timed to allow him to meet clients and let him observe the quality of interactions between staff and residents. This also gave residents the opportunity to speak to him if they wished. Staff indicated that Adviser and APO visits were very low key but that they did speak to residents. One staff member said he doubted if the children and young people understood who they were. They were not in often enough for the residents to see them as Knott’s boss. They generally spoke to the manager rather than the rest of the staff. That said, at least two

former residents recalled the Adviser by name and could describe his appearance, though they had also met him in subsequent care placements.

Dean House

3.105 The current Constitution dates from 1992. The previous arrangements, set in place between 1931 and 1959, were those which applied at the time of the abuse and are described here.

3.106 The Trust was run by a Board of Governors comprising a large number of ex officio members including representatives of the legal, medical and education professions and the Church of Scotland. There were also provisions for the appointment of other individuals. The local authority was represented on the Board by one or more elected members. It is clear that the Trust was a prestigious body. Since our remit includes an obligation to find out whether any reports were made before the police investigation which ultimately led to the convictions, and whether the response to those reports was appropriate, we require to examine the respective responsibilities of those involved in running the homes.

3.107 The Dean Orphanage and Cauvin Trust's constitution set out the respective responsibilities of the Governors and staff. The Governors were to:

- exercise general supervision and control of the home;
- arrange for the admission and removal of children; and
- appoint officers in charge.

3.108 They could delegate any powers and duties to a House Committee.

3.109 In practice, the Board met three times a year. It dealt mainly with finance and the running of the Trust. More direct work relating to care was conducted by the House Committee which met monthly. It was composed of some Board members, and some persons interested in the welfare of the children. A number of them lived near the Home.

3.110 The Inquiry could discover no formal remit to the House Committee setting out its functions and powers. A former Chair of the House Committee, and later of the Board of Governors, described it as the "socks and pants committee." It "ran on good will." Nevertheless, it had in fact weighty responsibilities. It received reports from the officer in charge. The Constitution allocated responsibility for supervision of the officer in charge jointly to the Committee and the Board. The Chair of the House Committee attended meetings of the Board, but was not a member of it.

<p>Lesson 26: Dean House was said to have run "on good will," for example as regards the involvement of neighbours on the House Committee. Also the Board ran on the basis of trust. There was no clear allocation of roles and responsibilities and no clear accountability.</p>

3.111 The Constitution also set out the role of the officer in charge:

Each officer shall, subject to the supervision of the governing body and of any house-committee which may have been appointed, have the direct control of the home to which he or she is appointed, of the children resident in the said home, and of the staff attached to the home, and shall be generally responsible for the whole discipline and organisation of the home and for the welfare of the children resident therein.

3.112 The Constitution recognised that the officer in charge would have a great deal of responsibility and authority, and therefore of power. The Governors' responsibility was to appoint and, jointly with the House Committee, to supervise him.

3.113 The local authority Social Work Department contributed to supervision of the Home through the Liaison Officer to the Voluntary Sector. In 1987, the Temporary APO charged with that task had had that remit added to his main task which involved the closure of a number of children's homes. He did not find the job a pressurised one. He visited Dean House at least monthly. His role was to be the "inspecting person", but he claims never to have fully understood what it comprised. He does not remember having a written remit, but was conscious that he was responsible for the Department's linkage with the organisation; that he would be expected to be aware if anything was going severely wrong. His line manager was the Assistant Principal Officer for Children, and through him to the Assistant Director, Residential & Day Care. The Assistant Director, Residential & Day Care who held that post from 1983 indicated to us that, in his view, the role was an embryonic version of what became the registration and inspection function, but he conceded that the expectations in that respect were not entirely clear. He was expected to act in an advisory capacity to the voluntary organisations to which he was assigned. He would also have an input into decisions about their funding by the local authority. When McLennan wrote to the Inquiry, he spoke approvingly of that external monitoring role.

Lesson 27: The Social Work Department's link officer with Dean House does not remember a written remit and was not quite sure of his role.

3.114 The Assistant Director, Residential & Day Care who held that post from 1975 to 1983 confirmed that demands on field workers meant they may not have given children in residential care as much time as they needed.

Lesson 28: Demands on field workers meant they did not give children in residential care as much time as they needed. Social workers should avoid the temptation to believe that, when a child enters residential care, responsibility is passed to the residential workers. The reality is that the young person needs their social worker more than ever at that point.

e. Issues

3.115 A number of issues emerge, many of which seem to apply to at least two, and often all three, of the homes involved. These are included in summary of issues relating to past which is set out at the end of Chapter 4.

3.116 Some of these concerns were also touched upon by the Emergency Services Manager, on behalf of staff currently working in the Emergency Social Work Service Team in Edinburgh, who sent the inquiry a paper entitled "Lothian Children's Homes in the 1980s."

Its aim was “to reflect the knowledge that Emergency Duty Team (EDT) staff had of the operation of Children’s Homes in the 1980s.” The following are extracts from that report.

The culture of social work in the 1980s was different and young people with complaints were not necessarily believed. Independent disciplinary investigations were not common.

Children’s Homes were not stable and at any one time one or more units might be in a state of crisis - a circular effect of poor staffing, poor physical conditions and sometimes of difficult behaviour from young people..... There was no clear guiding philosophy in residential child care and units would develop their own culture based upon their unit manager. This could vary from the libertarian to the tightly and physically controlled. Until 1991 the residential and day care section provided their own system of management support out of hours.

This was also in the context of a large Regional Assessment Centre used as a control mechanism.....

4. RESPONSES TO REPORTS BY VICTIMS

A. Introduction

4.1 Our remit required us to ascertain whether any allegations had been raised prior to the commencement of the police investigation and to determine whether any reports were made which were not acted upon. If there was a failure to act, we were to find out why that failure occurred. We were also to determine whether the response at the time was appropriate.

4.2 Because the Council was refused permission to sit through the private court hearings, the detail of such allegations and attempts by the children and others to report them were initially known to us only from press reports. We analysed these press reports and correlated them with information given by those victims who accepted our invitation to talk to us about their experiences. These activities led us to identify a number of situations that could be classified as “reports made.” We have supplemented the specific verbal reports with information about less explicit behaviour by children and adults which appear to have been an attempt to get those in authority to sit up and take notice. We conclude this section of the report with a description of the report which was responded to and which ultimately led to the conviction of Knott and McLennan.

4.3 The following are the “reports” and “behaviours” which we have investigated:

a. Clerwood

Reports

1. Child J said she told a member of staff.
2. Child D said Child C tried to tell but was not believed.
3. In 1993, Child B gave some information to the police.
4. A woman is said to have either witnessed the immediate aftermath of an abusive incident or to have been told about it.
5. Child A was said to have received hospital treatment after abuse by another resident, but police were not informed.

Behaviour

1. Children called McLennan a “Perv.”
2. Child E wrote a poem about the abuse which was read by a member of staff.
3. Children regularly ran away from Clerwood.

b. Glenallan

Reports

1. In 1979, Child G and Child K passed a note to staff about G’s abuse by slipping it under a door.
2. In 1992, Child G reported his abuse to a social work criminal justice team.
3. Child H wrote a book referring to his abuse, at the suggestion of a social work therapist and later told a social worker.

Behaviour

1. Three staff said to have resigned at one time.

c. Dean House

Reports

1. Child M said she reported her abuse and was questioned at a police station.
2. In 1981, Child N reported her abuse to her mother and was questioned by police.
3. In 1993, Child N raised the matter again with her former care worker in.
4. Around 1993, Child N told her Probation Officer about her abuse.
5. Around 1990, Child O told a worker in a subsequent placement.
6. In 1995, Child O told a social worker in the criminal justice team.
7. In 1982, Child P told of his abuse and was interviewed by the Governors.
8. Child Q said he told classmates and teacher at his special school.
9. In 1993, Child Q told a trainee psychologist.
10. In 1987, Dean House staff reported concerns to the Director of Social Work.

Behaviour

1. Children made comments about McLennan.
2. Children made formal complaints about McLennan's use of alcohol.

4.4 Each of these "reports" and "behaviours" will be discussed in turn.

B. Clerwood Report 1- Child J said she told a member of staff.

a. Child J's Report

4.5 Child J was abused by McLennan at Clerwood. She did not respond to the Inquiry's invitation to come forward with information. Press reports indicated that, when she made the report to the member of staff, she did not go into detail about the allegations. Those who heard her evidence at the trial indicated that J had said that the member of staff had not believed her.

4.6 Child J's reaction to this lack of response was to run away continually and to instigate name-calling by the children in which McLennan was called a "Perv."

b. Conclusions

4.7 This may have been a report made by the child, but we do not have sufficient information to draw any conclusions about it.

C. Clerwood Report 2 - Child D said Child C tried to tell but was not believed.

a. Child C's Alleged Report

4.8 Child D claimed that Child C, who had been abused by Knott, had tried to tell someone but had not been believed. We put this to C who said he could not remember trying to tell, although it might have happened.

b. Conclusions

4.9 There was insufficient information to pursue this matter further.

D. Clerwood Report 3 - In 1993, Child B gave some information to the police.

a. Child B's Report

4.10 In June, 1993, B had gone to the police because of concerns about the safety of her own children. The police view is that she did at the time have a "hidden agenda" but was reluctant to discuss it. She gave a statement to a male detective constable at St Leonard's police station about her own experiences at Clerwood at the hands of Brian McLennan. She did not however name him, but referred to him as "Alan." She told the Inquiry that she "bottled out" at one point and was unable to give a full statement. She had found some details of the abuse too embarrassing to talk about. Nevertheless, her statement, which we have seen, contained specific detailed allegations of repeated acts of abuse.

b. Action Following the Report

4.11 The police officer subsequently contacted the then child protection co-ordinator at the Social Work Department whose enquiries focused on the identity of "Alan." The co-ordinator emphasised to the Inquiry that his recollection of events was very clear because he had from the outset recognised the significance of the allegations. His enquiries had involved perusal of personnel files and asking questions of personnel and other managers who had been in post at the time of Clerwood in an effort to trace any record of any member of staff at that home who had that forename. He had been requested to adopt a low key approach by the police who were concerned that the alleged abuser might be alerted to their interest.

4.12 The police telephoned the child protection co-ordinator twice to check whether he had found such a person. Eventually he had to admit that he had no information. He did not feel he could take matters further and was not surprised that the police did not proceed further with the inquiry.

4.13 Our understanding is that, in the absence of identification of a perpetrator, coupled with the anxious and somewhat confused account given by B, it was decided not to pursue further the 1993 allegation at that time. The police have indicated to us that, in reaching this decision, the Force policy of timing, pace, location and duration were strictly adhered to. When B felt she could go no further, her feelings were respected. They said she was advised that, at any time she felt able to have this pursued, the police would be more than supportive in her efforts to seek justice.

c. Links with the 1996 Police Inquiry

4.14 Later, when the Inquiry embarked on as a result of Child G's allegation of abuse at Glenallan was extended to Clerwood, a link was made with B's earlier allegation. McLennan was now identified. B was the first and at that time the only person to have made any allegation in relation to him.

4.15 The police learned that McLennan had subsequently moved to Dean House where he would have had further access to children. It was suggested that senior officers may have had concerns regarding the resource implications of an extensive inquiry. Certainly, the inquiry which ultimately did take place made huge demands on police manpower and resources. However, enquiries were carried out at Dean House and led to a considerable number of subsequent charges.

4.16 B's 1993 statement was lodged by the Crown as a production in the trial with the intention of strengthening the witness's credibility by indicating that she was not part of a "bandwagon" effect of allegations about McLennan, but that she had reported the matter independently. In the event, the statement was used by Defence Counsel to cast doubt on her credibility and reliability in that the contents of the statement had material differences from that she had given in court. One major discrepancy, but far from the only one, was the use of the name "Alan."

d. Retrospective Views - Police

4.17 The senior police officer who conducted the later investigation expressed a personal view that the 1993 police inquiry was inadequate. He believed that police awareness of these issues by that time was such that greater efforts should have been made to follow up B's original interview and to interview other children who may have been resident at Clerwood at that time. It was known that many who alleged sexual abuse did not give the complete account of such matters at an initial visit. He maintained that the subsequent course of his inquiry demonstrated the value of his and his officers' approach, which involved patient, continuous support over a period of time before the whole account would be given. As he subsequently expressed it to us, he believed that police awareness of these issues by that time was such that greater efforts should undoubtedly have been made by both police and the Social Work Department to follow up B's original interview; more determined, structured lines of enquiry undertaken to identify both the perpetrator and the other children mentioned in B's statement, with a view to carrying out structured interviews of these children. He placed the major responsibility for that on the Social Work Department.

e. Conclusions

4.18 Clearly a report was made. The resulting response was limited. The police have indicated to us that, in their view, the inquiry was taken as far as possible with the information available at that point in time. We have been informed that such investigation as was carried out was undertaken by an officer from the Women and Child Unit. We believe this to have been an appropriate use of their experience and expertise in such investigations. The issue remains as to whether or not further enquiries should have been made in order to identify the alleged perpetrator who might still have access to children. A reasoned explanation has been given to us as to why further demands on B would have been inappropriate at that time. We can understand the thinking behind this approach. Nevertheless, we have concluded that greater effort could have been made to have further meetings with B who by then was an adult with children of her own.

4.19 We would also have thought it appropriate for such enquiries to involve the Social Work Department in a more active way than was done. During the public hearings, we were informed of the practice of joint interviewing of children in regard to allegations of sexual abuse. Such a practice is in any event widely recognised now as the appropriate way to obtain evidence from children. There seems every reason for extending the practice for vulnerable children to vulnerable adults in a situation of this kind. Social work training and experience could assist and complement police investigative abilities. We do understand that adults who were abused while in care might not welcome the idea of further involvement with the Social Work Department. Nevertheless, only if the information is passed to the Department can it take action to protect other children from similar abuse. Three of the victims who spoke to us (including B) were motivated partly by their concern for their own children's safety. Communication to victims of an understanding of the Department's role in protecting children might encourage their co-operation.

4.20 The Social Work Department had a clear responsibility to consider whether other young people cared for by them or other authorities might be at risk from the alleged perpetrator "Alan." This responsibility was fully recognised by the child protection co-ordinator, but his ability to take matters forward was restricted by his understanding that it was a "police inquiry." Even if the police inquiry was concluded in the way it was, we believe that it would have been appropriate for the Social Work Department, through their child protection officer, to have approached B themselves. Such an approach, which would require the understanding and co-operation of the police, could have resulted in providing appropriate support for a mother who was expressing anxiety about her own children (albeit that they lived in the area of another authority). It might also have encouraged B to have spoken more fully to the Social Work Department about the matters which she had raised with the police. It might further have enabled the Department to act appropriately in relation to other children looked after by them if it transpired that "Alan" was still employed in a position which meant he had contact with young children.

4.21 In conclusion, we would not suggest that, on the basis of the information initially provided to the Detective Constable, it would have been appropriate to embark on a major exercise of interviewing those children who had lived in Clerwood at the time when Child B was resident there. The inability to identify any alleged perpetrator would, in our view, have made this inappropriate at that stage. We are satisfied however that further efforts should have been made to encourage a fuller and more detailed and accurate statement from B, and if such enquiries did result in a coherent allegation with an identified perpetrator, that further enquiries on a wider scale would then have been appropriate.

4.22 Our inquiries of the police have elicited the information that, at the time of B's report. The police felt unable to challenge what they perceived as an inadequate response from the Social Work Department. They inform us that such a referral mechanism to a higher managerial level between them and social work is now in place.

<p>Lesson 29: The investigation which ultimately led to the High Court trial was helped by the fact that the police continued contact with the victims and moved at their pace.</p>

Lesson 30: In areas of joint responsibility, when both police and the Social Work Department each have potential responsibilities in respect of an allegation, and a decision is taken not to proceed further, that decision should be taken at a senior level within the police service and the Social Work Department.

E. Clerwood Report 4 – Report or witness of aftermath of abuse

a. Reports of the Incident

4.23 Child D recalled an abusive situation in the stables at Clerwood, involving himself, his sister (Child A) and Knott. He said that a woman came to the door and saw them. The children were in a state of undress. They were taken to the house, but nothing else seemed to have happened.

4.24 Such an abusive incident was also described in evidence to the court by Child I, who has a severe degree of learning difficulty. He said he had been posted as the look-out. He said no-one had come to the stables, but that he had told a female member of staff about it.

b. Conclusion

4.25 We were unable to find any further information relating to these allegations, and are unable to reach any conclusion. Clearly, if any member of staff had witnessed such an incident, or been informed of it, she would have had a duty to report it at a senior level.

F. Clerwood Report 5 – Report of hospital treatment after alleged abusive incident

a. The Incident

4.26 Another incident, similar in some respects to Clerwood Report 4, was reported by Children A and D, although in this case, the abuse of Child A was said to have been perpetrated in the stables by another resident. She said she had been taken to hospital and then returned to Clerwood, and that the police had not been informed.

4.27 Enquiries made by us and the police at the hospital about medical records relating to the allegation produced no results. Neither of us was able to obtain any information to indicate that the child, whose other medical records we have seen, was ever in hospital in regard to allegations of sexual abuse. Nor, insofar as we have been able to see the case records, is there any indication of such an alleged incident in the child's file.

b. Conclusions

4.28 We were unable to find any further information relating to this allegation, and are therefore unable to reach any conclusion.

G. Clerwood Behaviour 1 - Children called McLennan a "Perv."

a. The Behaviour

4.29 As set out in Chapter 3, former residents of Clerwood described how the children had a practice of climbing a tree near the staff room window and shouting "Brian's a Perv."

One resident who spoke to the Inquiry and took part in this practice (Child E) stated that her view was that this was a deliberate if unarticulated attempt by herself to draw staff's attention to their concerns. The only staff response was to tell the children to come down and behave themselves.

4.30 Another resident who had been identified as the ringleader in this shouting (Child J) did not accept the Inquiry's invitation to speak to us. Others to whom she had spoken formed the impression that this was the child's only way of fighting back with the possible hope that someone on the staff might ask about it. If so, it failed. No staff member appeared to appreciate the potential significance. We were advised that name-calling of staff, sometimes with a sexual connotation, was commonplace for children in care at that time.

b. Conclusions

4.31 In terms of the Inquiry's remit, this was not a "report" as such, but may well have been an attempt by children to draw attention by their behaviour to what was happening to them. The only response by staff was to tell the children to behave themselves. No attempt was made to ask them why they were shouting such a phrase. There was no indication that the behaviour was such as to be brought to the notice of field work staff. We make no criticism of staff at that time for not having identified the name-calling as a potential cry for help. However, the lesson to be learned is that any child, and particularly a young child, may experience difficulty in articulating complaints against staff in relation to inappropriate behaviour by them. The potential relevance of such name-calling should be considered in the future.

Lesson 31: Residential and field work staff should recognise that name calling may sometimes be a child's way of crying for help. Any such incident should be analysed and, where appropriate, followed up by appropriate and sensitive questioning.

H. Clerwood Behaviour 2 - Poem read by a member of staff.

a. Child E's Account

4.32 Child E told us of a poem she had written in which she had made reference to sexual abuse perpetrated on her while resident in Clerwood. In court she gave evidence that she was abused by McLennan, but also that Knott had induced a child to abuse her. She could not recall the terms in which the reference was expressed nor how explicit it was.

4.33 She told us that the poem was read by the officer in charge and that he had asked her about the contents, but she would not speak to him about it. He asked her if he could have the poem and she refused. Later she discovered that the poem had been removed from her possession and she suspected that this had been by the officer in charge because of the interest he had expressed in it. He denies having stolen it from her and says he cannot remember how it came into his possession.

b. The Officer in Charge's Account

4.34 When we interviewed the former officer in charge, he indicated at first that he could not remember the resident concerned. Subsequently, he remembered both the resident and the

poem. To him it had represented “the anguish of being in care.” He claimed to be so touched by it that he decided to keep a copy. He had kept it at his home for many years, was not sure whether he still had it, but promised to search for it. Having sent three reminders, we eventually received a typewritten copy of the poem on 19 January; the day prior to finalisation of our report. He told us that he had no knowledge of the whereabouts of the original document. The poem says:

You all pretend to care
You all say “I know how you feel”
But you don’t
A few sympathetic words is your strength
You all refuse to dig deep
And see what the real trouble is
You are all meant to be qualified for the job
But how can you when you have never experienced what we have.

c. Conclusions

4.35 The officer in charge’s response to our interest surprised and concerned us. We had paid particular attention to this matter because of our knowledge of his friendship with Knott and tried to consider whether his retention of the poem might have been influenced by a wish that the contents should not be read by others. We found it strange that he should initially claim not to have recalled the child, yet been so impressed by a poem that she had written that he had retained it within his home for many years. We asked him whether he made a practice of retaining such items as his own property. He told us that he had two other pieces of writing given to him at a much later time. Neither of them had any connection with his time at Clerwood.

4.36 We believe that the poem represents another example of a young person attempting to express a concern about her plight and that that attempt, albeit seen by an adult, did not receive a response that encouraged her to give greater detail about what the “real trouble” was. It would be hard not to be moved by the poem’s powerful terms. The officer in charge’s description of “anguish” is apt. It also underlines in the clearest way that children’s messages may be given in many ways and may be oral or written. Earlier inquiries have exemplified that children may express concern in writing and drawing as well as orally.

4.37 In terms of the Inquiry’s remit, this was not a report as such but an attempt by a young person to express feelings about what was happening to her. It appears that the officer in charge did try to raise the contents of the poem with the child.

<p>Lesson 32: Social work staff should recognise the possibility that young people might express unhappiness and concerns in different ways. Their training should stress the importance of “hearing” children in this way and interpreting and evaluating its significance.</p>

I. Clerwood Behaviour 3 - Children regularly ran away from Clerwood.

a. The Behaviour

4.38 Child E told us that children ran away from Clerwood every other week, but that they were just disciplined on their return and sent to their beds. The staff made no real effort to discover why the children kept running away in such numbers. In this resident's experience, the children's hearings which she attended did not ask either. We learned that the evidence of another child, who did not accept our invitation to meet with us (Child J), confirmed in the trial that she was a regular absconder.

b. Conclusions

4.39 We appreciate that the history of residential care demonstrates that young people who are required to live away from home by compulsory orders frequently abscond. Such a practice was almost anticipated in the 1970s and, as testified by the department's arrangements to log all occasions, and the figures provided for us by the police, remains a common feature today. We further recognise that the reasons for children absconding are many and complex, and that the vast majority may not reflect that anything untoward was being done to them. Nonetheless, at the very least, absconding indicates that, for some reason, the child is unhappy, albeit temporarily, about his or her position. It would seem common sense when a child absconds, that the real reasons for his or her doing so should be analysed and discussed with the child. It appears that such analysis was not commonplace at the time of the incidents which gave rise to our remit.

4.40 The most natural and immediate persons to discuss these issues with a child are the residential staff, and in all probability, the child's key worker. Recognising that children may have difficulty in articulating the reasons to those who care for them when these reasons relate directly to what is happening within the unit, absconding should also feature in the field worker's subsequent discussions with the child.

4.41 Earlier reports, including the Skinner Report, have acknowledged that absconding may be a response to abuse or other unhappiness, and have recommended that serious attention be given to finding out why children run away. We adopt that recommendation.

4.42 In terms of this Inquiry's remit, this was not a report as such. In the eyes of at least some of the children, this was their way of trying to express their unhappiness about the abuse to which they were subjected. The failure of staff to ask children about their reasons for running away and to reflect upon their having done so, whilst understandable in terms of the commonplace practice of absconding, means that the overall response was inappropriate to the children's needs.

<p>Lesson 33: The significance of absconding is an issue that has been identified in other reports which have acknowledged that it may be a response to abuse or other unhappiness and have recommended that serious attention be given to finding out why children run away. We add our voice to that recommendation.</p>

J. Glenallan Report 1- In 1979, Children passed a note to staff alleging abuse

a. The Report

4.43 In mid 1979, Child G, who was acknowledged to have been Knott's favourite, together with Child K with whom he was very friendly, wrote a note addressed to Mrs Knott. That note accused her husband of interfering with G.

4.44 We were given different accounts as to how this note was delivered and the action which followed from it.

4.45 *Account 1:* A staff member reported a clear recollection of the note being slipped under the staff room door on the ground floor, where it appeared "like a fax" during a regular mid afternoon handover meeting as the children returned from school.

4.46 *Account 2:* Mr and Mrs Knott were both very clear that it had been put under the door of the room in which they lived. The room was on the first floor. Child G supported their version.

4.47 There are varying accounts of what followed.

b. Child G's Recollection

4.48 The staff went into the office for a chat about the note. Knott came to G and said: "Now you've blown it. We can't have our "special thing" any more." He said it would all end up with him being in jail and then G would have "two dads" in jail. G was in tears. Knott urged G to say it was a lie. He was taken into the office where he was "grilled" by staff and forced to say it was a joke. He withdrew the allegation to protect Knott. Child K was then ordered into the office. The staff were shouting and bawling at him. He was punished for a period of 24 hours by being put in an assessment centre. Child G was forced to apologise. He was told by Knott and his wife never to talk about it again. The abuse started again that night.

c. Knott's Account

4.49 After reading the note, he arranged for his wife and another staff member to interview G. G withdrew the allegations to them. The whole matter was discussed at a staff meeting. The note was left in the log book and remained there until the closure of the unit when it was sent with the other staff documentation to the Department's headquarters at Shrubhill House. Knott (who had admitted certain offences in respect of G) told us:

I told [Adviser A] about it. I decided to leave the note in the log book because it would have been more likely to raise suspicions if I had tried to remove it.

4.50 Knott informed us that no-one had ever asked him whether or not what was said in the note was true.

d. The Former Mrs Knott's Account

4.51 She had taken some part in seeing G after staff members had first spoken to him, although she was not employed at Glenallan at that time. She had previously worked there,

before her husband's arrival but, in accordance with Council policy, had transferred to another unit when they married. She was still, however, living at Glenallan with her husband. Her previous involvement meant that she knew the children, and she had been key worker to G. She did not at that time believe the allegation contained in the note. She thought two factors were behind it: G's jealousy of her relationship with her husband, and the adverse influence of Child K, the co-author of the note. She had told her husband that the matter had to be sorted out, that others had to be brought in, and the note had to be reported to Headquarters. She said this had been done and that the note was "investigated" by social work Adviser B. She recalls a meeting in the office involving G, another member of staff, her husband and possibly the Adviser. G was insisting that the note was true. She had asked if she could come into the meeting. She did so, and spoke to G on a one-to-one basis. She told him that she had got his note and was concerned, and she felt it was due to jealousy about their marriage. G broke down and cried and admitted his jealousy. He then withdrew his story. She had been anxious that management be fully informed of the allegation so that, as she then saw matters, her husband's name would be cleared of lingering suspicion.

4.52 She further raised doubts as to the adequacy of her husband as a manager, and said that these deficiencies were known to his line managers and Advisers. This had led to Knott being ordered to take leave within weeks of their marriage, and very shortly after his appointment.

e. The Senior Social Work Manager's Account

4.53 We spoke to the senior social work manager to whom the Adviser at that time would have reported. He gave us the name of a third Adviser (C) who, he said, was involved in the investigation of the allegation. She had retired shortly thereafter and now, 20 years after her retirement, was unable to recall the incident. He related that the allegation had been known to him and his superiors; that their response was determined by the fact that the allegation was anonymous and that Glenallan was regarded highly as a facility for the care of children; that he had telephoned the police to discuss with them whether the making of such an anonymous allegation would be something which should be the subject of a formal report to them, and that their response had been that it would not.

f. The Junior Staff Member's Account

4.54 She was unclear about what had happened after the note was pushed under the door, but thought that senior staff must have taken a decision. The matter was talked about in the unit. Knott told them that he had spoken to the authors of the note who had retracted this, and said it was just a nasty, vicious way of getting attention. He had told them that both boys had been interviewed and that G had broken down and confessed it was his idea. They all heaved a sigh of relief. She could not recall any punishment being meted out. She is very clear in her recollection of the knowledge of some parts of the content of the note. For example, she recalled that part of the letter was scored out and redone. "This has gone on since you came here" was changed to "since I came here." Her recollection was that the note was addressed to staff and not to Mrs Knott. The staff in their meeting had all read it and looked at Knott. "He was deadpan."

4.55 This staff member was encouraged to reflect on her own experience at that time and the closeness she had already commented on (in Chapter 3) between Knott and G. In particular, we wished her to consider whether, having observed that closeness between the child and the member of staff, she had not reflected whether there might be truth in the allegation. She replied: "I couldn't believe that someone I thought I knew, that is Gordon, could possibly be having that kind of contact with a child. I don't think I ever thought about it." She acknowledged that, at that time, she was a very young, inexperienced and untrained person, and believes that, if a similar situation arose now, her level of suspicion would be a great deal higher.

g. Further Investigations

4.56 In the light of the varying accounts which had been given to us, efforts were made to ascertain further information. We tried to communicate with Child K, but he did not respond to our letter. We ascertained from the police that no record would now exist of a telephone conversation of the kind which the senior social work manager said he made. A particular difficulty lay in our attempts to identify the Adviser to Glenallan at that time. Three names had been mentioned to us by former staff and residents. Advisers A and B both denied any knowledge of the events, or even having responsibility for Glenallan at that time. Responsibility for particular groups of homes seemed to have changed frequently, and available records did not clarify the situation. Adviser C, now 20 years into retirement, understandably finds it difficult to recall events.

4.57 There seemed to be confusion as to the respective roles of "Adviser" and what was then a senior position of "Residential Care Officer" (which later evolved into Assistant Principal Officer.) We could not ascertain from the Social Work Department records the identity of those who had particular responsibilities at the critical time.

h. Conclusions

4.58 In terms of the Inquiry's remit, notwithstanding the various accounts, a clear allegation was reported to staff. Given the length of time that has elapsed since the note was written, the extent of discrepancies in recollections is understandable. Some of these discrepancies are irrelevant for our purposes; others are more significant. In particular, it was acknowledged by unit staff and by G that the identity of the authors of the note was quickly established. It seems strange therefore that the external managers are reported to have responded on the understanding that it was anonymous. Someone was not telling the truth. Either the staff at Glenallan did not tell the external managers that the identity of the authors was established, or the external managers knew and reacted very inappropriately in not following through an established allegation by an identified child. What is clear is that a child reported that he had been abused by Knott as long ago as 1979 and the lack of any significant action indicates a highly inappropriate response by officers of the Department at some level.

4.59 The action taken was inappropriate in other ways. Even in the culture which obtained in 1979, the child who had made the allegation should have been interviewed by persons who were not junior members of staff, and certainly not related to the person against whom the allegation was made. The pressure on the child to withdraw the allegation, and the

relief with which that withdrawal was met, clearly demonstrates the need for any investigation of allegations of this kind to be made by persons not directly connected with the unit.

4.60 In a subsequent section of the report dealing with the present, in 1999, we refer to investigation of such allegations in the present day.

Lesson 34: Pressure should not be put on residents to withdraw allegations. This instance seems to have proceeded on the basis of not believing G. This has hopefully changed. The Orkney Report made recommendations about responses to children telling about abuse.

Lesson 35: Withdrawn allegations should be kept on record.

Lesson 36: Allegations should not be investigated by people with responsibilities within, or line management for, the unit involved.

K. Glenallan Report 2 - In 1992, abuse reported to a social work criminal justice team

i. Child G's 1992 Report

4.61 G told us that Knott's abuse of him, which was the basis of the note referred to as Glenallan Report 1 above, tended to recur in his thinking and remained a source of anxiety for him as he grew up. Some time after his marriage, he told his wife about it. On 14 October 1992, when he was 26 years of age, he was required to see a social worker from the criminal justice team in connection with the preparation of a social enquiry report for a forthcoming court appearance. His wife, who had previously urged him to take some positive action in regard to his previously expressed concern on what had happened to him in Glenallan, urged him to take this opportunity to talk about the abuse with a social worker.

Lesson 37: Victims may later disclose abuse to social work in a different context; in G's case, criminal justice.

4.62 At his social work interview the nominated criminal justice social worker asked G to tell him about his life. G told him that the reason his life was so messed up was because of his treatment at the hands of the Social Work Department whilst he was in care.

4.63 The accounts given by G and the social work staff that we have interviewed largely agree up to this point. Thereafter, their recollections differ in material aspects.

j. The Perspective of G and his Wife.

4.64 After that initial reporting, nothing happened. A week after G had made the report, they were told that the criminal justice social worker who had received it had moved on. G was subsequently imprisoned. He thought someone might come to see him in prison about what he had said. Initially, no-one had done so. Later he recalled having a visit by a person he identified as the then District Client Services Manager. When released from prison, he asked his wife whether anything had happened. She said it had not, and he decided to take it no further. He felt the Social Work Department had contributed to the sentence of imprisonment through what he saw as the inadequacy of their report which contained no reference to the

allegations of abuse whilst he was in Glenallan. His clear recollection is that he received no advice from any officer in the Social Work Department as to what he could or should do. The next time he mentioned the abuse was to another member of the Social Work Department. That arose from a chance meeting. What he told that social worker on that occasion triggered the whole High Court trial.

k. The Social Work Department's Perspective.

4.65 In connection with our inquiry, we interviewed a number of social work staff from that time. These were:

- the criminal justice social worker
- the social worker's Practice Team Manager
- the social worker's District Manager
- the District Client Services Manager
- the Head of Criminal Justice Division for Lothian Region.

4.66 We were provided with the following documents:

1. Letter from the social worker to G dated 9 October, 1992, fixing an appointment for 14 October, 1992, in relation to preparation of the social enquiry report.
2. Letter from the social worker to the District Manager dated 15 October, 1992.
3. Letter from the District Manager to the social worker dated 20 October, 1992.
4. Letter from the social worker to G, dated 19 October, 1992.
5. Social enquiry report for G's appearance in court on 26 October, 1992, completed on 22 October, 1992.
6. Case notes for G, with entries for 18/10/92, 19/10/92, 22/10/92, 30/10/92, and one hard to decipher date.
7. Letter from the District Client Services Manager to G, dated 27/10/92.
8. Excerpt from court records indicating that, on 26 October, 1992, G failed to appear in court and a warrant was issued for his apprehension, and that, on 3 November, 1992, he was sentenced to 3 months imprisonment in respect of the original charge for which he had been due to appear on 26 October.

4.67 From their recollections, supported by the written information listed above, the Department's position can be summarised. The social worker took G's allegations seriously. He found G's allegations credible. He believed the matter to be so important as to merit immediate communication to the District Manager. He did not recall informing his then Practice Team Manager, but that person did have a vague recollection of the social worker having done so. In the letter to the District Manager, he indicated that G had not identified the staff member who was the subject of the allegation; that he wished to discuss the issue with his wife before doing so; and that he believed the staff member was still in the employ of the Social Work Department, but working with the elderly.

4.68 The District Manager replied promptly. He urged the social worker to continue his efforts to obtain the staff member's name with a view to the Department "or more likely the police" carrying out an investigation. He referred the matter appropriately to the Client Services Manager.

4.69 The social worker had by that time, on 19 October, written to G arranging a further appointment for 22 October, and expressing the hope that he would by then be able to address the outstanding issues after discussions with his wife. Later on 19 October, the social worker called at G's home and met his wife. This visit was prompted by activity in the preceding weekend by the Emergency Duty Team in a matter unrelated to the court appearance. On 22 October, the social worker had a meeting with G who then disclosed the name of the alleged abuser. The social worker passed the name to the Service Provision Manager who informed him that the person had worked in child care and subsequently with the elderly, but had now "retired." The social worker then passed that name to the Client Services Manager, and believes that he similarly informed G, who seemed relieved that Knott no longer worked in child care.

4.70 The Client Services Manager wrote to G on 27 October, inviting him to meet himself and the social worker on 2 November to discuss the allegations. G and his wife deny ever receiving this letter. Nevertheless, they seemed to have some knowledge of the arrangement. On 29 or 30 October (the date has been changed), the social worker noted that he "Called to confirm appointment with [Client Services Manager]. [G] not available. Mrs [G] said that her husband had "done a runner" from the court because he thought he was going to be imprisoned, but intended coming on Monday." The next record in the notes is dated 2 or 3 October and refers to an event on 5 October. This would make sense only if November were substituted for October. The social worker acknowledged to us that this was a likely error. As written, the note reads: "Appointment with [Client Services Manager] not kept. 5 October saw Mrs [G] in street. Mr [G] arrested and sentenced to 3 mths for contempt of court. N.F.A." We interpret this as meaning "No Further Action."

Lesson 38: G's 1992 report to criminal justice workers is hard to follow because of sloppy record keeping on the part of the social worker, including illegibility and occasional difficulties in identifying the author. Some of this was due to it being written up in haste because of the impending departure of the worker.

4.71 As there was a warrant for his arrest in existence at the time, it may not be surprising that, despite his wife's assurances, G did not keep the appointment with the Client Services Manager and the social worker on 2 November. The Client Services Manager states that thereafter he wrote to G and advised him that he should notify the police of his allegations. The letter was sent to his home address. The Department have been unable to produce a copy of that letter for us. Nor have they, understandably with the passage of time, been able to trace the disk on which the transcript of the letter is contained. They maintain that the letter was sent to G at his home address. If it were so sent, then it was sent at a time then the Department knew, or ought to have known, that G was in prison. Again, G and his wife deny that any such letter was ever received.

4.72 As indicated above, G maintains that he was visited in prison by the Client Services Manager, and that he was not visited by the social worker. Although the social worker is adamant that he visited G in prison, there is nothing in the case records to indicate that he had done so. His own recollection is that the visit took place on 27 November, which was his last day in that job. The fact that this was his final act in that post was presented as an indication of his own frustration that the matter had not been satisfactorily progressed. It might also

explain why no record was subsequently made of it. The social worker explained to us that it had been made clear to him that the decision about how to proceed was to be left with G. His visit to him in prison had the purpose of encouraging him to take the matter forward, but G was very vulnerable and did not want to “stir things up.” The Client Services Manager is adamant that he never visited G in prison, although G maintains that he did. Enquiries with the prison indicate that they do not retain records for that length of time as to which social workers visit prisoners.

4.73 The Client Services Manager’s recollection is that the case just appeared to lapse. The Department felt that G himself should be left to take the initiative to get back in touch. From the Department’s point of view what they had was an unwritten allegation made by a person who had not gone to the police about it. They were concerned that G seemed unwilling to go to the police. They were also concerned about the rights of the ex-employee against whom the allegation had been made. They did not think it proper that they should spread an unsubstantiated rumour. There was also some suspicion in the Department that G’s disclosure, made at a time when he was charged with a criminal offence, might be an attempt to divert attention from the offence and somehow minimise any penalty.

4.74 The Client Services Manager concluded that, with hindsight, perhaps the Department should have pursued the matter. However, he considered that our collective understanding of how to deal with these difficult issues was bedevilled by hindsight. At that time, there was no departmental procedure or guidance about how such issues should be tackled. They had given the disclosure serious consideration and applied their judgement to it. Even today, there would remain issues about timing and how such matters should be pursued. He speculated about whether the progressive removal of discretion in these matters would cause some future inquiry to record that people had thereby been discouraged from reporting.

4.75 This question was raised with the current Planning, Purchasing and Commissioning Manager (Criminal Justice). With regard to whether it was good enough to leave it to G to decide whether or not to take the matter up with the police, he replied that that might have been the advice given in 1992. Even up until a few years ago, there was a predominant culture favouring the self-determination of the client. More recently there had been a greater awareness that the client’s right to confidentiality and self-determination is qualified by community safety issues.

I. Conclusions

4.76 We were impressed by the account given by G and his wife. The detail they provided as to how they kept relevant, important papers and documents in a briefcase, and their insistence that they, perhaps particularly G’s wife, recognised the crucial importance of this issue, had all the marks of people giving an honest account. If the letter advising G to notify the police was sent soon after the meeting on 2 November, it would not have been received by G since he was in prison. His wife was the guardian at that time of the “briefcase”. She insisted that, had such a communication been received, she would have taken the letter to the prison during one of her regular visits. G was equally clear that it was because “nothing had happened” that he did not proceed further with the allegations on his release from prison. Nevertheless, one cannot discount the possibility of some failures of memory.

The Gs could recall neither the letter allegedly sent after 2 November, nor the letter inviting G to that meeting; yet Mrs G appeared to have had knowledge of it when the social worker, according to his records, called on her on 29 or 30 October.

4.77 It ought also to be noted that that the records which the social worker kept, as he himself conceded, lack completeness and accuracy.

4.78 The letter which the Department recalls having sent following the 2nd November meeting date was an important document and one which they ought to have been able to prove was sent. However, no separate record of outgoing mail was maintained and no record of transmission was available. They did not send it by recorded delivery. Even if such a letter was written, there is no departmental record of any follow-up, although both accounts acknowledge that a member of the Social Work Department did visit G in prison.

4.79 Further, the letter should have been sent to G, not at his home address, but to him in prison. Although there is no record of the criminal justice team having advised the Client Services Manager of the sentence, since they knew of his involvement in regard to the allegation which had been made, they should so have advised him.

4.80 In any event, a letter from the Department advising G to take matters forward with the police would, we believe, have been by itself an insufficient response. We believe that efforts should have been made to support and accompany him to the police in regard to the allegation to ensure that the matter was properly investigated. G was in a non-enviable position in making a report to the police. He had just been involved with the police in regard to a criminal offence. He had previous convictions for offending. He was not well disposed to the police. It was naïve to expect that someone in his position could easily have reported the critical and sensitive allegation about Knott to police officers. The allegation was that the offences had taken place whilst he was in the Social Work Department's care, and they had a clear duty to help him report the matter responsibly.

4.81 Even if G declined to go to the police, we have concluded that the Department had a responsibility, due to the nature of the allegation, to institute a referral to the police themselves; not least since that allegation had been accepted by the criminal justice worker to whom it had first been made as being credible and reliable. We accept that at that time there was lack of clarity for criminal justice and other social workers as to how to respond to incidents of this kind and whether the responsibility should be left with the person who had the information. We recognise that, without the complainers' account, the police might have been powerless to act. Nonetheless, had the matter been reported to them by the Department, they would have been in a position to carry out enquiries with G and encourage him to repeat the account which he had already given to the criminal justice worker. We agree with the Purchasing, Planning and Commissioning Manager, Criminal Justice, that the question of confidentiality should not preclude social workers acting in this way. Whilst we accept that initially they should do all they can to encourage a client to make the allegation and to support them in doing so, we believe their responsibility to others may outweigh their individual duty of confidentiality to the individual client who has provided information to them.

4.82 The 1994 child protection guidelines, which post-date this report by G, advise against “precipitate action” but indicate that an inter-agency discussion should take place to identify any current risk posed by the alleged perpetrator. It also suggests that it would be helpful for the person reporting the abuse to have an informal discussion with the Police Women and Child Unit before making a formal statement. We were advised that, if a similar situation arose today, there would be at least a discussion with senior police officer who would have checked out the background of the alleged perpetrator. The value of this would be dependant upon the co-operation of the person reporting the abuse.

4.83 Although they had learned that Knott was no longer in the employ of the Department at that time, they did not and could not have known that, if the allegations were correct, as the criminal justice worker believed they were, Knott was still not in a position to carry out similar abuse of others in the community. While it may be suggested that knowledge of the prevalence of sexual abuse of children was scanty at the time when that complained of was perpetrated in the 1970s and early 80s, by the time G made the allegations to the criminal justice worker in 1992, it was, as demonstrated by the social worker’s action of reporting to his superior, a phenomenon widely recognised in the social work profession. In these circumstances, we believe that the Social Work Department had a clear duty to report allegations of a serious crime to the police so that they could be thoroughly investigated.

4.84 Had they carried out the duties which we believe to have been incumbent on them, then the police enquiries might well have been instituted some four years earlier than they were when witnesses’ memories would have been at least that bit clearer. Had it not been for a subsequent chance meeting between G and another member of the Social Work Department in 1996, the allegation might never have been investigated at all; these serious crimes would have gone unpunished, and there would have been no recognition that so many children in care had been abused in the way that they were.

4.85 Staff have represented to us that, by finding that further steps should have been taken, we are seeking to introduce retrospective duties which did not apply at that time. It remains our considered view that, in the light of the gravity of the allegation and the then position of the officer in charge for looking after children, the lack of further action was inappropriate.

Lesson 39: There should be recognition of the possibility that former residents who may have been involved in offending behaviour or who may, as in G’s case, be in prison, may be unwilling to involve the police. This should not be taken as an indication that what they are saying is not true.

Lesson 40: There is a need for guidelines on responding to allegations of historical abuse.

Lesson 41: If a decision is made to proceed no further with investigation of an allegation of historical abuse, the reasons and authority for that decision should be recorded.

Lesson 42: There is a danger of assuming that an allegation by a person faced with a criminal charge is a “smokescreen.”

Lesson 43: Too much emphasis on client self-determination regarding reporting and investigating allegations is misplaced when the safety of children is at stake.

Lesson 44: Regarding G, it is critical to reinforce the need for allegations to be properly investigated, and to be clear about action to be taken when staff become aware of a complaint of this nature but are unable to persuade the complainer to go to the police with the allegations. Guidance on responding to allegations of historic abuse should include some latitude to staff to encourage and assist complainers to report the allegations, allowing appropriate time to pass to enhance their chances of doing so, rather than a blanket instruction to report allegations themselves immediately which might have the result that the essential evidential information from the complainer is never forthcoming.

L. Glenallan Report 3 - Child wrote a book about abuse and later told a social worker

a. The Book

4.86 Child H, who gave evidence in court alleging abuse by Knott, had been encouraged in his late teens by his social worker to write his life story as part of therapy for himself. The young man had had a troubled life and had been resident in Glenallan until he was 12. Thereafter he was adopted and that adoption failed. He did write two chapters of his life story dealing with his time in Glenallan and his time with his adoptive parents. We recognise the value of social workers encouraging young people who have experienced a troubled life to write in this way.

4.87 The two chapters of his “life story” were lodged in court as a production. He made it clear that he enjoyed and valued the care which he received in Glenallan, with the exception of the allegation against Knott. Part of his ultimate allegation is graphically explained in the publication lodged in court which the Crown used to exemplify that the young man had given this account of abuse long before the police enquiry which led to the trial. In the book, he had originally named Gordon Knott, but on sending it off to various publishers, the true name of Knott had been deleted and a false name put in.

4.88 In terms of our remit, we were concerned as to whether or not he had received any advice to change the name. He said that none of the social workers who had known about the book had actually read it.

b. The report to the social worker

4.89 He did however say that, when he was 18 or 19, he had met one of his former social workers and went for coffee with her. He claimed to us that he had told the social worker about the abuse perpetrated on him by Knott. He gave a clear account of the place where this conversation had taken place. He had named the social worker to the police, and also named her to us. He told us that she had denied that he had told her about the abuse and commented, “She would - she’s a social worker.”

4.90 We interviewed the social worker. She recalled meeting the young man and having coffee with him. She explained that he was at the time facing lots of difficulties in development and behaviour, and was saying a great number of things to her about his past and his behaviour, some of which related to sexual matters unconnected with Knott. Amongst these matters he included a suggestion that he had been abused while he was in Glenallan. She claims to have a very clear memory of having spoken to the young man at that time and asking him to reflect on what he was saying and to recognise that, if it was true, he had a

responsibility to consider other young people who might be being looked after by this person. She says that she neither believed nor disbelieved him, but was very anxious that he think seriously about the allegation and, if it were true, that he should take appropriate action. It was one of a number of things that he was talking about at that time and he did not take the matter further. In the light of the confusion in the young man that she observed at that time (he himself admitted that it was his “glue-sniffing period”), she did not feel she could rely on what he had said.

c. Conclusions

4.91 We are not in a position to make a judgement as to which of the two accounts of a casual meeting a long time ago is the more reliable. That said, we were impressed by the careful explanation the social worker gave. She explained that she had not taken a note of the matter and kept it in case records because the young man was not at that time part of her caseload. She cannot recall whether or not she discussed it with a senior colleague. It is right to record that, having seen the detailed statement in the productions and the allegations contained in the indictment, the young man gave evidence that the abuse amounted to more than that which he had alleged in his book. When we asked him for an explanation, he said that, as time had gone by, he had remembered more about the behaviour of the man and that was why he was able to remember what Knott had done in greater detail after he had completed the book than he had done at the time.

4.92 In terms of our remit, that was certainly a report which was claimed to have been made, although it appears that it may have been made in an atmosphere of some confusion and as part only of a greater mass of issues. We make no criticism of the social worker in respect of her actions. We do however take this situation into account later in our report when we consider the response of workers to allegations of abuse.

Lesson 45: Where any person makes an allegation at any time that he or she was abused during childhood when the local authority had responsibilities in respect of that child, the allegation should be recorded and discussed with senior colleagues.

d. Observations

4.93 Finally, we should say that the young man’s book is an impressive piece of writing. It certainly impressed Counsel during the trial and it had a similar effect on us. It presents a very helpful, practical insight into what life in care was like for this primary school child; what he perceived as the strengths and weaknesses of the residential care system and the staff who looked after him, including his field social worker. It comprises a very telling account of a breakdown of adoption and the subsequent difficulties which he experienced. The writing is of such value that we would recommend that consideration be given by the Department to publishing that document which the young man has tried vainly to have published and to have this available for use for social work education purposes in training. We believe that it would be a valuable source of training material for residential and field staff which would have greatly additional relevance in respect that it stemmed from actual experience by a City of Edinburgh child who was looked after by the local authority Social Work Department and workers. Clearly the child’s views would require to be balanced by input based on professional experience and theory. We understand that, if it were given favourable

consideration, the young man would be agreeable to making the document available for that purpose.

M. Glenallan Behaviour 1 - Three staff said to have resigned at one time

a. The Background to the Resignations

4.94 Former residents G and L told us that three members of staff had resigned simultaneously in an attempt to draw attention to concerns. Two of the three staff members confirmed to us that they and another staff member had discussed their growing concerns in relation to poor management at Glenallan and that they had jointly decided that they would resign simultaneously in the hope that this would alert senior management to these difficulties and that they would be asked why they wished to resign. They said their concerns were not directly related to abuse but, on later reflection, did involve practices which provided opportunities for it, for example, the fact that staff were often left to do shifts on their own.

4.95 The staff members felt that they had been unable, despite their good relationships with the Adviser and Assistant Principal Officer, to raise their concerns with them. Opportunities to do so had arisen through these persons' occasional attendance at staff meetings, although these had also been attended by Knott. One of the staff members indicated that such issues that they had felt able to raise during these meetings might have appeared to have been petty and insignificant.

b. Action Following the Resignations

4.96 In the event, any hopes that a joint resignation would lead to a more general and thorough enquiry by senior management were not realised. The resignation of the two members of staff to whom we spoke were presented in April or May, 1980, and were accepted. According to them, the third member of staff "withdrew her resignation" and, as a consequence, was appointed to the resultant position of assistant officer in charge. The two to whom we spoke simply left after the appropriate period of notice. One of them still expresses surprise that, so far as he knows, senior management never made enquiries about the resignations. Certainly, no one ever asked him for his reasons.

c. Knott's Perspective

4.97 Knott said he recalled the resignations of the two members of staff to whom we spoke, but he had not linked them. He had no recollection that a third member of staff had resigned at the same time or that, because of the changes which took place, she was then placed in a promoted post. If she had been placed in a promoted post, it must have been for a very brief time on an acting basis, as he named another person who, he said, was appointed to the assistant officer in charge post.

d. The External Managers' Perspective

4.98 Neither the then Assistant Principal Officer, nor the person who we believe to have been the Adviser at that time, could remember any such resignations. As the Adviser put it to us, "I certainly do not remember hearing of any issue over "mass resignations" either from

[the Assistant Principal Officer] or from personnel, and no complaint was made to me.” Each indicated that, though frequent turnover of staff was very much a feature of residential care at that time, if three members of staff had resigned simultaneously, they believed they would have recalled this, and they further believe that they would have tried to discover any hidden reason behind the resignations. The then Director of Social Work confirmed to us that, if three members of staff did resign at one time, he thought this was a matter which should have been thoroughly investigated by external managers.

e. Conclusions

4.99 In fact, depending on how quickly the third member of staff “withdrew” her resignation (and assuming that she did actually resign in the first place in accordance with her agreement with her colleagues) external managers may have known only of two resignations.

4.100 Given that fact and neither Knott nor the external managers can recall resignations being presented in this way, we believe that the lesson to be learned from this episode is that staff as well as children may resort to behaviours which they hope others will pick up on when they feel unable to articulate their concerns.

Lesson 46: External managers should enquire into unusual patterns in departure of staff.

Lesson 47: Bad management was felt to be the issue at Glenallan, but this was actually an abusive situation.

N. Dean House Report 1 - Child M said she reported abuse and was questioned by police

a. The Report

4.101 Child M is said to have reported abuse and been questioned at a police station.

4.102 As reported in the press, and as confirmed to us by Junior Counsel for the Crown, Child M gave evidence that she made a complaint about abuse by McLennan and as a result she was taken to a police station and questioned. At the police station she claimed to have been interviewed by a woman police officer who accused her of lying and slapped her on the face.

4.103 Child M did not accept our invitation to speak to us. Board Members of Dean House, including the then Chairman, had no recollection of such an incident being reported to them. He believed that, had such an incident been reported to him, he would have remembered it. Such staff as we met could not assist. The most thorough police enquiries, including attempts to interview all women police officers who had been stationed at the relevant police station at that time, could find no trace of any report of such an allegation, or the child being taken to the police station. The police observed that this did not mean that the incident had not taken place as described. Police recording systems were much less exacting, compared with today.

b. Conclusions

4.104 In the absence of any further information, we are unable to classify this as a “report made” and consequently to comment on “appropriateness of action.”

O. Dean House Report 2 - In 1981, Child N reported abuse and was questioned by police

a. The Report

4.105 N was one of four sisters, all of whom were resident in Dean House (at overlapping rather than at the same times), along with two brothers. She is the immediate younger sister of M. In 1981, when she was nine years old, she reported to her mother that she had been abused by McLennan. Her mother reported the matter to staff and insisted that they call the police. Although it is accepted that a police enquiry took place, no records relating to it can be found and the officers involved were never identified.

b. N’s Recollection.

4.106 N says she was interviewed by a policewoman at Dean House for half an hour. The meeting took place with her sitting on the bed where the abuse had occurred. A second officer was present throughout, standing by the window. N had wished her mother to be present, but the police would not allow this. She said the police officer did not believe her and slapped her on the face, which resulted in her agreeing (wrongly) with the officer’s suggestion that she was telling lies.

c. M’s Recollection

4.107 Junior Crown Counsel informed us that N’s older sister (M) had given evidence that, having left Dean House by that time, she was visiting with her mother and standing outside the door while N was being interviewed by the police. She had heard the slap, and gone into the room to find her sister crying.

d. Staff Recollections

4.108 N’s then key worker told us that her recollection of the incident was hazy. She said she had been involved with the police interview and recalls N feeling intimidated and requiring comfort, but does not recall her face being slapped. She was sure that the police investigation did not go beyond the individual child and that no attempt had been made to interview other children.

4.109 McLennan denies the abuse. He has attributed N’s allegation (and the other sister’s) to the instigation of the child’s mother, who by then had a grudge against the home. The key worker recalled that the allegation was made shortly after the child had been on a home visit, and she too at that time, but not now, believed that the child had been set up by her mother to make a false allegation.

e. Police Recollection

4.110 Although it was clear that a report had been made to the police, their records provide little information about the nature and extent of the enquiry.

f. The Medical Examination.

4.111 Arrangements were made for the child to be medically examined. The examination was conducted by a consultant physician at the Department of Genito-Urinary Medicine at the Edinburgh Royal Infirmary. It disclosed no evidence to substantiate that abuse had taken place. The consultant herself in court indicated that it would have been more appropriate for the child to have been examined by a police surgeon.

g. Dean House Documents and Governors' Recollection.

4.112 The Governors recalled the parents of N as persons who were difficult. The Governors had not believed that the officer in charge could have acted in the way that had been alleged. Minutes show that McLennan had offered to resign on the allegation having been made, but such an offer was not accepted or seen as appropriate. Nor did it seem to have been considered appropriate to suspend him whilst an investigation took place. The investigation involved the police, the Social Work Department and the medical examination. Despite their disbelief of the allegation, the Governors had recognised the gravity of the matter and were reassured and relieved by the police response and the result of the medical report which they interpreted as supporting the confidence they had in McLennan's denial. Minutes at that time recorded the recognition of the anxiety that the unsubstantiated allegation must have caused McLennan, and their expression of "full support and sympathy" to him.

h. The Social Work Response

4.113 The children's social worker from that time recalled the allegation and the fact that his own knowledge of the regular complaints made by the parents inclined him to accept the view taken by the police. He did not recall discussing the matter with N. He told us that he did not believe at the time that abuse had taken place. He had no idea "that such things happen." At that time he was recently qualified. He told us that had consulted fully with his senior social worker, area officer and the Assistant Principal Officer in the Residential and Day Care Section who held responsibility for voluntary organisations. We have not been able to locate any record of that officer's response. He is now living abroad and we have been unable to trace him. The social worker recorded the allegation and the information available for the children's next "in care" review, but did not include it in his subsequent report to the children's hearing when the child's supervision requirement was next reviewed. The Social Work Department did not see it as necessary to carry out an independent investigation from that conducted by the police, and appear to have accepted that the allegation was without foundation.

4.114 The Assistant Director, Residential & Day Care who took up post the year following this report indicated to us that the "mind set" at the time would have been that, if the police said the allegation was without foundation, no further action would have been taken. However he was also of the view that it should have been reported up to the level of Assistant Director, and that Directorate members, as well as the police and the Governors, would require to have been satisfied about the outcome of the investigation.

i. Conclusions

1. N impressed us as a young person who, despite the passage of years and the fact that she was nine years old at the time, gave a clear, credible account of what had taken place. Her subsequent reporting of matters to others (discussed below) supported the view we took of her reliability.
2. The absence of relevant police and social work records makes it difficult for us to test the accuracy of accounts given and action taken.
3. In terms of practice in 1981, the attitude taken by the Governors could not be classed as inappropriate. They knew that a police investigation had been carried out. The minutes of the Dean House Board reported that, following investigation by the Social Work Department and the police, no evidence appeared to have been found against Mr McLennan. It was not the then practice, and they received no advice from the Social Work Department in that regard, to suspend the member of staff against whom the allegation had been made whilst the investigation proceeded. However, the opportunity to investigate the matters with other children and staff outwith the presence of the officer in charge might have encouraged any or all of them to speak more freely and answer the questions in regard to him.
4. Similarly we cannot conclude that, in the practice that obtained in 1981, the attitude taken by the Social Work Department was inappropriate. We are however of the view that, even in 1981, improvements could have been made. The field social worker could have taken the opportunity to discuss this issue sensitively and individually with the child outwith the presence of care staff and of the police and that there were good reasons for doing so. We accept that this was an issue on which he might have expected to have guidance from his seniors. N had made a serious allegation. Either it was true or it was untrue. If true, then clearly this was a critical matter relating to the safety of the child. If untrue, the fact that it had been made, even at the instance of the mother, was a matter which required careful consideration in regard to the needs of the child and the ability of the mother to care for her. The actual interview with the police must have been a source of great anxiety and upset for the child and one which could have been addressed by her social worker. Further, there were cogent reasons why the fact that the allegation had been made should have been included in the report which he submitted to the review children's hearing for the child. At the very least, the allegation indicated an important fact relative to the child's care and the ability of the parents to care for her. His recommendation in that report was that the child should be returned to live with these parents. The knowledge that such an allegation had been made by the child was information which was relevant to the decision which the hearing members had to take. Though we appreciate that it was not at that time legally possible to require parents to absent themselves from part of the hearing, the information might have provided the hearing members with an opportunity to raise the issue with the child from an independent position, and she might in that context have been able to tell about what had taken place. In the context of the then legislative provisions, despite the social worker's concerns as to how the parents may have manipulated discussion relating to the allegation, it could have been possible for him to convey that information under a "caveat" that it might be in the best interests of the child for the substance of that part of the report to be withheld. In fact, the parents already knew of the allegation. Everybody knew about it except those charged with taking the legal decisions as to where the child should stay.
5. The medical examination should have been carried out by a police surgeon. Even in 1981, and as widely recognised today, these specialist doctors knew that abuse can occur without there being any medical evidence available to support the allegation. The report itself focused on genito urinary infection. The negative medical report was understood by the Governors and the Social Work Department staff to provide positive evidence in support of the officer in charge's denial.

Lesson 48: There is a need to set aside the prejudice engendered by people regarded as difficult when they are trying to raise concerns about the safety of children. Later on in this report we explore the issue of external supports for children in care. We note the importance of children having someone outside the Unit to whom they feel they can express concerns. Children choose the people they feel able to talk to. Sometimes the people most trusted by the child in that respect will be the child's parents. Even inadequate and/or difficult parents can sometimes be the child's most trusted confidantes. Even difficult people, holding grudges, can be right.

Lesson 49: It is dangerous to rely on a lack of medical evidence as conclusive proof that abuse did not take place.

Lesson 50: Children can be dissuaded from telling by insensitive or inappropriate handling of allegations.

P. Dean House Report 3 - In 1993, N raised the matter again with her former key worker

a. The Report

4.115 N told the Inquiry that, at some time in 1993, before the commencement of the police investigation which led to the High Court case, she was staying briefly in the Stopover hostel and met the member of staff who had been her key worker at Dean House. N had said to this person: "You didn't believe me when I told you about Brian." The staff member recalled N having said this to her, and believed that she may have indicated to her that she was right in saying that she had not believed the allegation. She had not discussed the matter fully with N in Stopover or earlier at Dean House. Having thought about the matter now, her view, in her own words was, "On reflection, I realise I should have spoken to my superiors in Stopover regarding this."

b. Conclusions

4.116 This conversation was more in the nature of a casual observation by the former resident than a formal report. There were no guidelines in force as to how reports of historical abuse should be dealt with. The former key worker knew that the matter had already been investigated and apparently concluded. We therefore make no criticism of the former key worker, but adopt her view that it would have been appropriate for her to have discussed the matter with her then superiors. Such a discussion would have provided an opportunity for independent, objective consideration of whether further action would be appropriate.

Lesson 51: Dean House – There is a need for guidelines regarding response to allegations of historical abuse.

Q. Dean House Report 4 - In 1993, N told her Probation Officer

a. The Report

4.117 N told the Inquiry that, at or about the same time as her report to the staff member at Stopover, she told her probation officer about the abuse. The probation officer has since died. On being advised of the allegation, the probation officer had contacted the person who had had been N's field social worker at Dean House. He arranged to meet her. N said she did not

really expect anything to happen as a result of this because she knew it had already been investigated by the police and she had not been believed.

4.118 She does recall that her former social worker, having received the repeated allegation from the probation officer, asked whether she hated him now for doing nothing about the allegation at the time.

4.119 The former social worker told us that their conversation centred on the way the allegation had been dealt with at the time. He was no longer N's social worker and did not consider he had a responsibility to take the matter further. He had encouraged her to talk to her probation officer.

b. Conclusions

4.120 The fact that the allegation had been raised again did provide a further opportunity for it to be re-examined. However, without any further information to cast doubt on a matter they believed had been dealt with, the action of the deceased probation officer and the former social worker was understandable given that there were no guidelines in force about how such reports of past abuse should be dealt with.

R. Dean House Report 5 - Around 1990, Child O told a worker in a subsequent placement

a. Child O's Account

4.121 O, the third of the four sisters, and the immediate younger sister of Child N, gave evidence in court that she was abused by McLennan at Dean House when she was aged 7. She repeated the allegation to us and told us that, well before the start of the police investigation that led to the High Court trial, she had informed two care workers at different times when she was resident in Danderhall (another children's residential unit). At that time she was about sixteen years of age. She initially told a night worker about the abuse, at the time when a fellow resident had been making unwanted sexual advances to her, and this had prompted her to speak about her earlier experiences.

4.122 She says that she also told her then key worker who is now dead and another permanent nightshift worker at the hostel.

b. The Night Workers' Account

4.123 We spoke with both night workers. They agreed that O had told of being abused by a male care worker whose identity was not disclosed. They had a clear recollection that the child told them that the allegation had been investigated by the police, but that there had been insufficient information to take it further. They took no further action personally but communicated the information to the child's key worker. They had thought that the matter would be reported to the unit manager and that it would have been discussed at a team meeting. The night workers' view at that time was that, as they believed the matter had been investigated previously, the most appropriate help they could offer O would be to allow her to talk about it, get over it and then "forget about it."

4.124 We raised these matters with the officer in charge. Though he remembered Child O, he had no recollection of having been told about the allegation. He was certain that, had such a matter come to his notice it have been included in the Unit's log books. We have been unable to obtain the log books for that residential establishment.

c. Conclusions

4.125 A report was clearly made to two night workers. Their understanding was that the allegation had previously been investigated and the matter concluded. In fact, no allegation had been made to the police in respect of Child O, although allegations had been made by O's sisters and the police inquiry with regard to these matters had concluded with no further action having been taken. The carers' understanding at the time was that the allegations were false and had been provoked by the child's mother.

4.126 The action of the night workers in supporting the child and informing the key worker was entirely appropriate. The Key Worker has since died.

4.127 The Social Work Department, through their officers, were given an opportunity in this situation to investigate the allegation made by O, but for various reasons did not take that opportunity.

4.128 There were no guidelines in force as to how reports of historical abuse should be dealt with. The night workers believed that the matter had already been investigated and apparently concluded. We therefore make no criticism of them.

Lesson 52: There is a need for guidelines regarding response to allegations of historical abuse

S. Dean House Report 6 - In 1995, Child O told a criminal justice social worker

a. O's Account

4.129 In May, 1995, O, then aged 20, was the subject of a probation order. She was due to appear in court in connection with a further offence. A social worker in the criminal justice team had been her probation officer (referred to here as probation officer 1) and had the responsibility for preparing a Social Enquiry Report for the court. O told us that, prior to his completing the report, during a particular occasion of which she gave very clear specification (although the date is unclear), she had been upset whilst discussing matters with him. He asked her what was troubling her and she told him of her memories of being abused by McLennan; that she had tried to bury the memory of that but, as with Dean House Report 5, the abuse had been brought to mind by some recent events in her life. The probation officer told her he would have to include that matter in his report, but she never heard anything further about it.

b. The Social Enquiry Report

4.130 The probation officer completed a social enquiry report which made reference, in very clear terms, to O's disclosure. It related that "When she was about eight or nine years old she and some of her siblings were in care at Dean House Children's Home, apparently run by

an independent charitable trust. She told me that she had been sexually abused by a male member of staff in the unit....”

4.131 We have been unable, despite our strong wish to do so, to interview this probation officer. Shortly after completing the report, he left the Department to work for another authority in Scotland. He has now left that authority and is believed to be living abroad. We have been unable therefore to speak to him directly, but his report and file correspondence indicates clearly the actions which he took. We would particularly have wished to have asked him about the date when the allegation was first made. We did speak to the probation officer’s then senior social worker. She indicated that the probation officer had discussed the matter with her, although O had initially told him “in confidence” and had not wanted the matter taken any further. Indeed, O had initially not wanted any reference to the matter to be contained in the Social Enquiry Report and, according to the senior social worker, had threatened not to talk to the probation officer again if he put it in. At no point had the care worker been identified by name, although the senior social worker’s recollection is that that the disclosure had been brought about by O meeting him in his then job as a bus driver. The senior social worker’s view was that they should continue to work with O towards obtaining further detail when she was ready to provide it, and accessing support through the rape crisis centre. No timescale was put on this process, with the concern being to go at O’s pace.

4.132 We have seen the social enquiry report which the probation officer completed. It indicates that, despite the fact that O had committed a further offence while on probation, he recommended that probation should continue. He had assisted O to move to another tenancy. That tenancy was outwith the area in which he operated, and the case would require to be transferred to another district. The report indicates that he had communication with a senior social worker in the district in which O was going to live, regarding transfer of the order.

c. The New Senior Social Worker’s Position

4.133 We had a meeting with the senior social worker. She recalled a conversation with the referring probation officer (probation officer 1) about O. During our meeting she indicated that she had a vague memory that he spoke about O having been the victim of sexual abuse. She has subsequently clarified to us that at no time did the probation officer indicate to her that the abuse was alleged to have taken place whilst O was a child or during her time in local authority care. She clearly told us that she had never seen the social enquiry report which set out details of O’s circumstances and, in particular, the specific allegation of abuse. The Departmental files to which we had access showed no evidence of any transfer report or summary, which would have been the normal practice when a case was passed to another office. There was speculation that the lack of transfer and summary might have been attributable to the author of the report’s departure from the authority’s employment. This was backed up by the probation officer’s senior social worker who recalled that he had in fact prepared the Social Enquiry Report prior to departure, but that it had been typed after his departure. The report itself is signed by her.

d. The New Probation Officer's Position

4.134 In the event, the court accepted probation officer 1's recommendation. A Duty Appointment was made for O on 30 May, 1995 which, according to departmental records, she did not keep. Neither did she keep a subsequent appointment which is recorded as scheduled for 12 July, 1995. The case appears to have been allocated to probation officer 2 on the client index record (possibly because she had been the duty social worker on the day of the scheduled appointment), although she was not aware of this allocation prior to her departure on leave for a four month period in May. During her absence, the case was therefore allocated to, a temporary social worker (probation officer 3), although the client index records were not altered. Probation officer 2 was ultimately given responsibility for the case on her return from leave in October, 1995.

4.135 Probation officer 3 told us that he had never seen the social enquiry report which had led to the court making the probation order. He knew nothing about the allegation of abuse while she had been in care, although he was aware that someone else was alleged to have abused O while she was in her late teens. As a newly qualified worker at that time, he feels he would not have been allocated the case had there been any indication that there were child protection issues.

4.136 His main focus of work was to assist O with a problem which he had related to over involvement with alcohol. As a criminal justice worker, his priority was to ensure that National Standards were carried out. The "criminal justice" files which had been opened originally by probation officer 1 and continued by them, had little detail of O's family background. This information would have been contained in the "children and families" file. Probation officer 3 indicated to us that he would have found it valuable to have such information available and suggested a need for application of information technology to ensure cross-referencing of files and summation of relevant information. He suggested that there were inconsistencies in filing practices within the criminal justice teams and the authority.

4.137 On return from extended leave, some four months into the new probation order, probation officer 2 assumed responsibility for the case. She recalls that the social enquiry report was not in the file at the time. On reflection she feels that it would have been advisable to have obtained a copy from the office previously holding the case. However, she had information from probation officer 3's case notes that O regularly used alcohol and that this was relevant to her offending. Probation officer 2's focus was ensuring that O complied with the conditions of her probation order, which included attending a groupwork programme run by a voluntary organisation. Probation officer 2 in fact made arrangements for this to happen.

4.138 Probation officer 2 did subsequently become aware of allegations that O had been subject to sexual abuse, but is clear that this did not relate to when O was a child, but when she was a young adult. This related to abuse by a family member who had now formed an association with a woman with children. O was reluctant to take steps in regard to this because she did not want to get her relative into trouble, but in fact seems to have put pressure on him to remove himself from the presence of these children, and used her contact with the Social Work Department to add weight to these efforts. Probation officer 2 advised O that she

could not ignore the possibility of abuse happening currently to children whose parents might be unaware of the risk. According to probation officer 2, O refused to report the matter to the police. Probation officer 2 then discussed the matter with her senior social worker. Following this discussion, probation officer 2 obtained the male relative's file to check whether any relevant information existed. Discussions took place with the duty senior social worker in the children and families' team. It was ultimately decided that no further action could be taken in respect of the allegations. The male was under supervision of a social worker in another criminal justice team. His living arrangements as known to this social worker were not those alleged by O. All staff involved were agreed that there were no current child protection issues. O had refused to go to the police, and the matter was concluded.

4.139 Unfortunately, these discussions and assessments were not recorded in either the male relative nor O's file – a situation which, in retrospect, is felt to be regrettable by the social workers and senior social workers involved.

e. The Practice Team Manager's View

4.140 The Practice Team Manager did recognise workers' responsibilities in terms of child protection guidelines. He accepted that there should have been some record made of the discussion between the probation officer and other staff in relation to the allegation of abuse by a person with access to children. Notwithstanding that his staff had taken action to satisfy themselves in relation to child protection issues, he felt that not all staff would necessarily operate in this way. He felt there was a clear need for consistent understanding and practice in this area. This view was similarly expressed to us by the Planning, Purchasing and Commissioning Manager for Criminal Justice.

f. Observations on National Standards

4.141 During discussions with these criminal justice workers, a number of general points were made about the needs of young people involved in offending behaviour who have had a disadvantaged background and/or been in residential care. A number of points were raised about the appropriateness of current National Standards for 16 to 18 year olds in particular and other vulnerable young adults, in relation to probation orders, community service orders and supervised attendance orders. The experience of workers suggests that many of these young adults lack the maturity and stability to recognise their responsibilities in relation to orders of this kind, and to the consequences in the event of their failure to meet the expectations of them. These failures can result in courts imposing alternatives when breach proceedings are instituted, as is required by National Standards, and prematurely lead to custodial sentences for immature young offenders.

g. Conclusions

1. Probation officer 1 appears to have had a positive working relationship with O to the extent that she was able to disclose the alleged abuse to him. He clearly identified the alleged abuse as a very significant factor – significant enough to discuss with his senior social worker, despite O's wishes that he keep the information in confidence. He also included the information in the Social Enquiry Report, despite O's initial reluctance. Although records are unclear, it appears that there was an understanding between probation officer 1 and his senior social worker that they would go at O's pace in seeking

to gain further information when she felt ready and able to disclose more detail. It is not clear however that this was set in any timescale, nor that a decision was taken as to any future course of action if further details did not follow.

2. In the event, this crucial information was not appropriately passed to the team taking over the case, either in a transfer summary or by handing over the Social Enquiry Report which led to the imposition of the probation order. This was inappropriate in that such omissions would be contrary to accepted practice.
3. The probation officers who accepted the transfer were never in possession of the full information relevant to the case and indeed the probation order. We have difficulty in understanding how the new probation officer would begin work with an offender without having this information, and in particular the contents of the Social Enquiry Report which led to the order being made.
4. The lack of information available to the new probation officers meant that they were unaware that this allegation had been made which meant that they were unable either to address this in the course of their work or to take this into account in considering the later allegations regarding the male relative.
5. This case again highlighted inconsistencies in record keeping and a lack of cross referencing between “children and families” and “criminal justice” files. The confusion over allocation of the probation order on the client index system proved to be unhelpful in seeking to trace who was responsible for the case at any point in time. We were unable to trace material which was reported to have been included in a “Restricted Access Module” in the case file. There were also significant gaps in other recorded information, which workers have accepted as inappropriate, and indeed they have made constructive suggestions as to how record keeping and filing can be improved in practice.

h. Observation

4.142 We sympathise with the criminal justice workers’ dilemma in relation to the appropriateness of probation and community service for immature young people. It may be suggested that consideration of this large subject goes beyond our remit. In terms of our remit, however, to consider the safety of children, we consider early introduction into the penal establishments is contrary to children’s best interests and their safety. In our view, the transition from “child”, particularly children whose needs have been addressed within the context of the children’s hearing system, to the adult criminal court, can be too sudden and inappropriate for immature young people. It seems inappropriate to exact the same standards and consequent alternatives in the event of breakdown for mature adults and immature 16 year olds.

Lesson 53: The demands imposed by probation, supervised attendance and community service orders may be too rigorous for 16 to 18 year olds, and even older young people, given that breach can lead to an early custodial sentence.

4.143 Recommendation 92 below, arising out of this insight, advises the Director of Social Work to raise this matter with relevant agencies with a view to instigating a revision of National Standards in this regard.

Lesson 54: Difficulties in transmission of information can follow on from the departure of staff .

Lesson 55: There is a need to cross reference to earlier files held by other divisions within the Social Work Department.

Lesson 56: There is a need for guidelines on responding to allegations of historical abuse.

Lesson 57: It is important that social workers in criminal justice teams are made aware of their responsibilities in the area of child protection. This case also raised issues for us about the unsatisfactory transmission of information. We find it difficult to understand how a probation officer could satisfactorily supervise a case without access to the information which persuaded the court to make a probation order. We also wonder about the suitability of probation for young people such as Child O with such a troubled history. One of the probation workers told us that she did not see herself as being there to befriend O. Her job was to carry out national standards and ensure that she adhere to probation terms.

Lesson 58: The question arises again about the responsibilities of the department with regard to ensuring the safety of other children if a full disclosure is not made.

T. Dean House Report 7 - In 1982, Child P told and was interviewed by the Governors

a. Child P's Recollection

4.144 Child P, who was resident in Dean House between the ages of 9 and 13, gave evidence in court that he was abused by both McLennan and Cull. Though attending normal school whilst resident in Dean House, he subsequently sustained serious head injuries and now experiences severe learning difficulties.

4.145 We met P with his support worker. P told us that Cull had abused him a few times before he told anybody about it. He had been afraid to tell, but by then he "had had enough." He told Cull that he was going to tell about the abuse. Cull said he would call his bluff and took him to the staff room to talk about it. Later on he went to the Boardroom. The abuse stopped after he had told people in the Boardroom. However, he did say that, after the event, although the abuse stopped, he was "sent to Coventry" for some six months.

b. Dean House Records

4.146 These show that the child's allegation was recorded on a statement made to Brian McLennan and an Assistant House Parent on 9 August, 1982. In addition to the sexually abusive behaviour, the allegation addressed other examples of improper or inappropriate behaviour. The statement had a note appended indicating "senior social worker notified by telephone 4pm." A report was compiled by the child's social worker on 3 September after she had spoken to P and his mother, in relation to the detailed allegations which P had made. She told us that this report and P's initial statement were sent to her Area Officer and the Divisional Director (both Field Services) and to the Assistant Principal Officer (Residential and Day Care).

4.147 Dean House constituted what they called a "Committee of Inquiry" which was held on 23 September, 1982.

4.148 The minutes of the Committee of Inquiry record that those present were two Board members (the Chairman and Vice-Chairman of the Board of Governors, both QCs), the supervising social worker, the officer in charge of Dean House (Brian McLennan) and the Assistant Principal Officer, Residential & Day Care "representing the Social Work Department of Lothian Regional Council." The minutes record that the child was brought into

the Boardroom and questioned about his statement outwith the presence of Cull. He consistently maintained that what he had said in his statement was true. Basically, the allegation was that Cull had handled P's private parts while the child was wearing his night clothes whilst watching television in a communal room with other residents. There was discussion about the "rough and tumble" in which Cull sometimes engaged. The note of the meeting records that P said that the abusive behaviour had been an isolated incident. It was observed that P displayed no ill-will towards Cull, with whom he said he had, on the whole, a good relationship. The other allegations were also discussed.

Lesson 59: Children may be inhibited from speaking if interviewed in very formal settings.

4.149 The child then left the Boardroom and Cull was brought in. He denied the allegation of sexual abuse and gave an explanation in relation to the other matters.

4.150 The Committee concluded:

The general feeling of the meeting was that [P]'s truthfulness was not seriously in doubt, but that the boy's recollection, or interpretation, of things said or done by Mr Cull might not be entirely correct. It appeared impossible to reach any firm conclusion about the incident referred to in item 1 [the allegation of abuse], and in view of the lapse of time since it was said to have happened and the absence of allegations of any other similar incident involving [P] or any other boy, it could now probably be treated as of little significance.

4.151 McLennan reported that:

Mr Cull had always been an entirely loyal and hard working member of staff, and that, while lacking in certain professional social work skills, he related well to the children and had much to offer to the running of Dean House. He was anxious to retain Mr Cull as a member of staff, and would regard any suggestion that he be dismissed as quite unjustified.

4.152 The local authority representatives are recorded as having expressed their agreement to Cull's continued employment at Dean House. The Assistant Principal Officer involved suggested that he "be encouraged to exercise more tact and self-control."

4.153 The Committee unanimously decided:

- That no report of the matter to the police or any other authority was called for, and that Mr Cull be advised of this immediately.
- That Mr Cull's employment at Dean House should continue.
- That Mr McLennan should do his best to impress on Mr Cull the necessity of being more circumspect in his language and general behaviour, and of conforming to general standards of child care. Mr Cull should also be warned that his progress in these respects would be monitored in future.

4.154 Copies of the report were sent to both local authority representatives and the Divisional Officer, Field Work (mistakenly referred to as Divisional Director of Social Work).

c. Child Protection Guidelines

4.155 The expectations upon both Dean House and the local authority with regard to involvement of the police would have been set out in the then current inter-agency child protection guidelines. Despite extensive enquiries, we have been unable to trace copies of the guidelines which were current in 1982. However, the immediately preceding guidelines for the period April, 1977 to October, 1980 note that, "As a general rule, the police should be involved where there are reasonable grounds to suspect that an offence has been committed." The immediately succeeding guidelines, which were in force from October 1983 until April 1988, make a stronger statement: "In all but the most insignificant cases therefore the police must be informed where there are reasonable grounds to believe that an offence has been committed even if it is not known by whom." It would seem reasonable to suppose that the intervening guidelines at least reiterated the 1977 advice.

4.156 The conclusion of the Committee of Inquiry that the allegation could probably be treated as "of little significance", together with the specific decision not to refer it to the police, at least indicate that they gave the matter some thought. Their decision could not therefore be identified as going against the then current guidelines. The local authority was kept fully informed, from the day when the first statement was made. They were also bound by the guidelines and might have themselves referred the matter to the police, but they similarly chose not to do so.

d. Retrospective Views - Social Work Staff

4.157 The then Director of Social Work expressed surprise that the report of the Committee of Inquiry had gone to the Divisional Officer, Field Work, rather than someone in residential care. He believed that the Assistant Principal Officer should have reported it to the Principal Officer for Children, and that it should have been considered by the Assistant Director for Residential & Day Care. Written procedures at the time would not have specified this, but given the fact that the conclusion was that the child should remain within a unit, albeit he was still maintaining that he had been abused, referral to the Directorate would have been appropriate and sensible. He further questioned the appropriateness of questioning a child in a Boardroom in a situation which must have been threatening for him. In his view, the interview should have been conducted outwith a formal setting. He also suggested that there would have been advantages if the interview of the child had been conducted by someone with social work rather than legal experience.

4.158 The then Assistant Director, Field Services, who had previously held the position of Assistant Director for Residential & Day Care, said she would have expected the Assistant Director for Residential & Day Care to have been informed. She believed that a more senior person ought to have attended the Inquiry, given the status of those who were present from Dean House. Their eminence might have presented difficulties for any junior member of staff should they wish to disagree with the Board representatives' conclusion.

4.159 When he spoke to us, the then Assistant Director, Residential & Day Care was clear that he had had no knowledge of Child P's allegation and the subsequent investigation. He would have expected to have been informed. He offered as a possible explanation the fact that he had taken over the responsibility for Residential & Day Care just days previously.

4.160 The Divisional Officer, Field Work, who spoke with us, reported that P's allegation had been the subject of discussion within the Social Work Department. The focus of the discussion was whether the young person was at risk in the placement and whether the Department should take any further action. The Department concluded that there did not appear to be any immediate risk to P. P himself had indicated that he wished to remain at Dean House. His mother and social worker were both happy for him to remain there.

4.161 The Divisional Officer, Field Work, considered that it is highly likely in a similar situation that the same conclusion might be reached today. It would however, have been made in a different context in which staff were more aware of the need for appropriate boundaries in their interaction with children. It is also more likely that a staff member today involved in this kind of situation would be subject to disciplinary procedures. Although Dean House was an independent organisation with its own disciplinary procedures, the Council today would require to be satisfied as to their adequacy. In 1982 there were no performance indicators for residential care. Staff were deemed to be doing a good job basically if they contained children. Today there were quality standards for residential care services which broadened the criteria for success. The Divisional Officer, Field Work added that one of the factors influencing the Department's agreement that there was no need for further investigation was that there had been experienced legal involvement in the Dean House Committee of Inquiry.

4.162 The supervising social worker now believes she "suspended belief" in regard to the child's allegations. Such suspension of belief was common in relation to allegations by children at that time. She now believes that she was over-influenced by the fact that the child did not want police to be involved; that he did not want to leave Dean House; and that, indeed, he did not want anything at all to happen. There was little experience or understanding of sexual abuse at that time and no awareness of its prevalence or how sexual abusers could operate within an institutional setting. She found P's statement to be truthful but was less sure of his interpretation, especially concerning the incident of alleged abuse which had occurred in a public lounge. Today, after subsequent training, she would have come to a different conclusion and would have wished different actions to be taken. If the situation arose now, the police would automatically be brought in as soon as the allegation had been made by way of a joint interview with police and social work staff.

Lesson 60: Staff accept their inclination was not to believe Child P.

4.163 Although P was the kind of boy who related easily to new people, and it is likely that he would have met the Chairman of the Board of Governors during his visits to Dean House, she considered it likely that he, like most children (and even adults) would have found his appearance before the Board of Governors a daunting experience.

e. Retrospective Views - The Dean House Governors

4.164 The then Chairman of the Board, who would have had the senior position in the Committee of Inquiry, could not recall how the child's allegation had arisen. He agreed that going to the Boardroom must have been an impressive event for a young boy but, on having refreshed his memory from the minutes of the meeting, indicated there was nothing that struck him as being wrong about the way in which the matter had been dealt with. The then

Vice-Chairman agreed with him about the propriety of the way the investigation had been handled. It had very properly involved the Social Work Department Residential Section and the child's own social worker. It would not, in his view, have been appropriate to refer the matter to the police because of the insufficiency of evidence. The matter could not have been pursued in the criminal context without corroboration. Further, there was a marked difference between the nature of the allegation made by Child P in respect of Cull and that made by Child N in respect of McLennan. Child N's was a much more serious allegation and the alleged perpetrator was the officer in charge. With regard to P, the allegations were not so serious and involved a more junior member of staff. The sexual incident alleged was an isolated one. The view had been taken that it would have been somewhat "heavy handed" to have taken the matter to the police. The former Vice-Chairman also noted that, whilst there was a clear duty to care for the children, the Governors as employers had to ensure that there was fairness of investigation so far as the interests of their employee were concerned. The existence of industrial tribunals and the need to give warnings unless misconduct was gross imposed clear responsibilities on the Governors.

Lesson 61: Cull's situation demonstrates the implications of employment law for child protection.

4.165 The minutes and supporting information give little detail about the accountability or transfer of information between the House Committee and the Board of Governors. There was no formal remit to the Committee of Inquiry. The Chair of the House Committee at that time (who became Chair of the Board of Governors in 1985) advised us that she had not seen the report of the Committee of Inquiry until it was produced in court and she was questioned on it. She had first heard of the matter when the then Chairman, had advised her in general terms of the allegation that had been made. The sense at that time was that the experience of the Chairman and Vice-Chairman was such as to make it desirable that they should deal with the allegation and the inquiry on the basis that that was in keeping with their work experience. She recalled no formal communication of the Committee of Inquiry's decision in the minutes of the House Committee or the Board. In particular, she had never known that one of the decisions of the Committee of Inquiry had been that Cull's "progress on these matters would be monitored." The responsibility for monitoring this progress would have fallen upon the officer in charge.

Lesson 62: There is a need for clarity regarding the responsibilities of Board and Committee members of voluntary organisations.

f. Retrospective Views - Dean House Staff

4.166 The member of staff who had been third in charge at Dean House at the time said that she and her colleagues had not known about the incident or about the Committee of Inquiry. She had no knowledge that Cull's progress was to be monitored. In any event, he was supervised by the officer in charge, who would have that responsibility.

g. Conclusions

4.167 Child P made a very clear report of an allegation of abuse by a member of staff whilst resident in Dean House. Although the allegation was reported to the Social Work

Department, it was never reported to the police. An investigation was held which involved the Governors, staff from Dean House and representatives from the Social Work Department.

4.168 It was appropriate that an investigation be undertaken. Those who carried out that inquiry were, through their experience in court, well qualified to assess reliability of information.

4.169 In the light of the information available to the Committee of Inquiry, and the recommendations of the Social Work Department staff, the decision ultimately taken seems reasonable.

4.170 Nevertheless, while our conclusions would indicate that the actions taken in regard to this allegation were in many respects appropriate, we have also concluded that, even in 1982, improvements could have been made. These improvements are:

1. It would have been preferable if the Committee of Inquiry had interviewed the child in a less formal setting than the Boardroom.
2. The format and extent of the inquiry could have been improved. No consideration seems to have been given to interviewing other children whilst this serious allegation was investigated. Nor did any consideration seem to have been given to the member of staff being suspended at that time to allow children to speak more freely without his presence. In any event, it would have been more appropriate for interviews of that kind to be conducted by persons not directly involved in the management of the staff such as the officer in charge, but by a semi-independent source such as the Assistant Principal Officer of the Residential & Day Care Section. That person's investigation should also have included inquiries from other members of staff as to Cull's practice.
3. The allegation should have been reported to the Assistant Director, Residential and Day Care, and to the Assistant Director of Field Work, and to the Director of Social Work, in the light of the recommendation which was made that a child who reported abuse was to continue to reside in that residential establishment
4. Although the Committee of Inquiry recommended monitoring of the Cull's practice, this does not seem to have been carried out, or if it was, to have been recorded. Further, the remaining Governors and the later officer in charge who succeeded McLennan in 1988 whilst Cull was still in Dean House, had no knowledge that there had been an allegation made in respect of that member of staff or that his progress was subject to being monitored.

Lesson 63: Child P's report was made 1982. A lot has been learned since then about the prevalence and dynamics of sexual abuse. In particular, Lord Clyde's 1992 report into the removal of children from Orkney recommended (9): "The recipient of a confidence from a child must above all display sympathy and understanding and not transmit any element of disbelief." Recommendation 26 of the Finlayson/Newman report of 1993 was that "when a child has made an allegation of abuse, a decision be taken to identify a key individual who would have paramount responsibility to provide appropriate support to the individual child." Current child protection guidelines place greater emphasis on the involvement of the police. All of these post-date the 1982 incident, therefore it would be inappropriate for us to criticise the Governors or social work staff on that basis. However, should similar allegations be made in the future, those with responsibility for child care should be required to observe these three requirements.

Lesson 64: Only the officer in charge knew that Cull was to be monitored and, when he left, no staff member knew. When a decision is made to monitor the progress of a member of staff, there should be clarity about who should carry out the monitoring and how progress is to be recorded.

Lesson 65: Regarding the legal involvement in investigation of Child P's report, it is difficult not to come to the conclusion that, no matter how learned they may have been in their own profession, they would have benefited from some advice, guidance and training in relation to staff supervision and support and dealing with some of the personnel issues which frequently crop up in the voluntary sector.

U. Dean House Report 8 - Child Q said he told classmates and teacher at his special school

a. The Report

4.171 Q suffers from learning difficulties. He was resident at Dean House for most of the period from November 1978 to May 1983, when he was between 10 and 14 years of age. He alleged that he had been abused by both Cull and McLennan. He gave evidence to that effect in court and repeated it when he came to see us with his support worker, who had supported him through the lengthy police investigation and the court proceedings. His account to us was clear and detailed. He had attended a special school which had shorter hours than other schools. As a result he was often the only resident in Dean House during the afternoons. It was during these periods that he claims to have been abused by Cull. He gave a very telling account of how frightened he had been when Cull had been disturbed during one incident of abuse by another member of staff knocking on the door, and how he had been helped by Cull to "escape" from the room by the window into the garden. He indicated that the abuse by McLennan took place at night after he went to bed. Again, he gave a clear account of this behaviour, although McLennan has consistently denied that there was any truth in his allegations.

4.172 Q advised us that he had told his classmates and a teacher about his abuse. No-one had believed him. The teacher had said: "Don't be silly. Go out and shut the door."

b. Conclusions

4.173 Given the passage of time since the alleged abuse and the time-span within which the report might have been made (sometime between 1978 and 1983) it has not been possible for us to check with the staff at the school whether they have any recollection or record of Child Q having said what he claimed to us. We would doubt, given the informal way in which he advised us of the teacher's response, that any record would have been kept. His account to us, and in particular his recollection of "don't be silly" does exemplify the need for staff to be aware of the established evidence of the incidence of sexual abuse, and particularly that children with learning difficulties and those who live away from home may see them as appropriate persons in whom they may confide, whether or not they realise that such behaviour is inappropriate. A significant number of the young people to whom we have spoken have shown that they had considerable confidence and trust in their class teachers. Children with learning difficulties may be particularly vulnerable through an inability to articulate what has happened. That vulnerability should not be increased by failure of staff to recognise what the child has said or demonstrated, or by their rejection of it without appropriate action having been taken to investigate the matter thoroughly.

Lesson 66: Child Q - Education staff must be fully aware of the prevalence of sexual abuse and of their own responsibilities in terms of taking the matter forward. This is particularly so when children are living away from home. The presence of learning difficulties can make it more difficult for a child to identify and articulate their concerns (although Child Q seemed quite clear about it). Adults working with young people who have learning difficulties must be particularly vigilant about identifying when a child is trying to express concerns and in helping them to do so.

V. Dean House Report 9 - In 1993, Child Q told a trainee psychologist

a. The 1993 Report

4.174 In 1993, before the commencement of the police enquiries leading to the High Court trial, Q told a trainee psychologist that he had been abused by Cull. This had been prompted by his having seen Cull at the hospital at which he was then resident. The matter was immediately reported to the police.

4.175 The case was allocated to a uniformed Police officer who interviewed Q in the presence of his “appropriate adult” who was a staff nurse, and another officer. Q gave a detailed account to the officer of abuse by both Cull and McLennan. A detailed statement was also taken from the “appropriate adult.” Nothing then appeared to have happened, despite efforts by the appropriate adult to ascertain what was happening. Both Q and she felt that they were let down by the lack of information from the police. The appropriate adult recognised that it might be difficult to institute proceedings because of Q’s learning difficulty and a lack of corroboration, but she wished to be informed of the result.

4.176 We have established that the police officer, having taken the initial statement, recognised that this was an allegation which should be dealt with by the CID. He made appropriate arrangements to report the matter to the CID. That ended his responsibilities.

4.177 The case was allocated to a Detective Constable. According to the police, the “appropriate adult” eventually contacted the Detective Constable and was told that the police investigation could not be progressed as one of the named suspects had been interviewed and there was insufficient evidence to proceed. This response appears to have been without foundation.

4.178 During the course of the subsequent police enquiry which led to the High Court case, it became known that Q had raised the matter earlier. The officer in charge of the subsequent major inquiry took steps to recover the notebook of the police constable from the divisional filing system. He also recovered the original statements which had been passed to the Detective Constable to whom the inquiry had been allocated. The statements had in fact been left in the Detective Constable’s locker. It appeared that the officer had failed to continue the inquiries. We gather that some minimal inquiries may have been made at Dean House but these had failed to disclose anyone called “Mick” or “Brian” which were the names given in Q’s statement. By that time neither McLennan nor Cull were on the staff. Thereafter he appears to have taken no further steps. His own recognition of his failure may be reflected by his abandonment of the statements in the locker. We understand that the police have dealt with the Detective Constable through disciplinary proceedings. Further, we have been informed that they have taken steps to address the issue of failure of the Detective Constable’s

supervising officer to ensure that the case which had been allocated to the officer had been carried out.

b. Conclusions

4.179 The action taken by the Detective Constable was inappropriate. He is understood to have explained subsequently that he had no formal training in or experience of child abuse cases.

4.180 Further, the failure of the Detective Constable's supervising officer to ensure that the delegated officer had carried out the enquiries expected of him was similarly inappropriate.

4.181 The failure of the police to communicate with the management of Dean House or Social Work Department was inappropriate. Though Dean House was known to be an independent, voluntary establishment, the police would have been aware that the Director of Social Work had responsibilities in respect of children resident there.

4.182 Advantages might have accrued from an interview having been carried out with Q in terms of the now established practice (with regard to children) of joint interviewing with a person from the Social Work Department, albeit that Q was 26 years of age. We recognise that this is not established practice with regard to adults with learning difficulties and that Q had appropriate support from his "appropriate adult." That said, the officer appears, with the assistance of the appropriate adult, to have obtained a pretty clear account from Q.

4.183 Had the police investigated the clear allegations which had been made, they may have been in a position to instigate the eventual enquiry three years earlier than the actual enquiry. Failure to carry out enquiries into allegations of this nature could result in other children continuing to be at risk of abuse similar to that which was alleged.

Lesson 67: The case of Child Q shows the importance of senior officers following up what action had resulted from allocation of a case to a junior officer.

Lesson 68: Reports from young people with learning difficulties must not be undervalued because of the difficulties they present. This is also an issue for courts. There are indications that attempts were made to discount Child Q's evidence because of his difficulties. Children with learning difficulties are particularly vulnerable to abuse and have particular difficulty in articulating it and in being believed. This is a matter which requires attention at national level. Consideration should be given to the potential advantages of joint interviewing by police and social work.

W. Dean House Report 10 - In 1987, staff reported concerns to the Director of Social Work

a. The Report by Staff

4.184 McLennan resigned from Dean House in 1987, following a train of events initiated by concerns expressed by Dean House staff to the Director of Social Work. These events included the preparation of a report by the Social Work Department at the request of the Governors, based on a general investigation of the home and its management.

b. Relevance to our Remit

4.185 Our remit requires us to determine if “there were any reports not acted upon, and if so, why.” The report by the staff members was acted upon. We are also however required to determine the appropriateness of the action and to “identify any lessons that may be learned.” Our enquiries have therefore included consideration of the report and McLennan’s subsequent resignation.

c. The Background to the Report

4.186 The report was the culmination of staff concerns about McLennan’s management abilities, his drinking whilst on duty, and the staff’s ability to communicate their concerns to the Governors. They maintained that they had tried to speak to the Governors, but felt blocked by the omnipresence of McLennan. They had formed the view that the Assistant Principal Officer from the Social Work Department, who was the Department’s appointed link with Dean House, was a friend of McLennan’s and that he was not prepared to act. The Assistant Principal Officer is adamant that he was not a personal friend of McLennan and that the staff members never approached him about these matters nor asked him to act. He has indicated to us that, to the best of his knowledge, prior to the submission of the letter from members of staff, he had not been made aware by either staff or Governors of previous incidents or actions in relation to McLennan’s drinking. Nor did the letter to the Director of Social Work suggest either that he was a friend of McLennan or that he had been approached unsuccessfully by them in an attempt to have their concerns addressed.

4.187 Two members of staff contacted the British Association of Social Workers and were advised to communicate their concerns directly to the Director of Social Work. They did so, and recounted nine occasions when the officer in charge had, according to them, been under the influence of alcohol whilst on duty, behaved offensively to staff, deliberately misled staff, abused his position as officer in charge by leaving the house whilst on duty, and mismanaged staff rotas to the inconvenience of staff and residents. They specifically claimed that they “do not seem to be heard by the Board of Governors despite our numerous attempts to inform the Governors of this grave recurring problem.”

4.188 The Governors had themselves by that time begun to lose confidence in their officer in charge. The longstanding Chairman, who had had a close working relationship with McLennan from the time of his appointment had, as a result of an approach by a staff member, been required to speak to McLennan about his drinking alcohol. He himself had never seen McLennan adversely affected by alcohol. He reflected that it may have appeared to the staff member that there had been no response to the expression of concern as he could not recall feeding back any information about his discussion with McLennan.

4.189 In 1987, his successor as Chairman had spoken to McLennan on a number of occasions on matters which caused her concern, including absence from duty and other matters relating to alcohol. She indicated to us that, on each occasion, McLennan had been able to reassure her that: (1) the House had never been left unattended; (2) other members of staff had covered for him at all times; and (3) his absences had been reasonable in the circumstances. She stated that, at that time, she met regularly with other members of staff, both singly and together, and that at no time had they ever suggested that either of the first

two statements was false, although they may have suggested sometimes that the third was a matter of opinion. Like her predecessor as Chairman, she stated that she had never seen McLennan adversely affected by alcohol.

4.190 She did not accept the suggestion by staff about their repeated attempts to bring concerns to the attention of the Board. She had been disappointed to discover that they had found it necessary to write to the Director of Social Work. There was also a suggestion that McLennan's rude behaviour in the presence of officers from the Social Work Department may have caused Governors concern because of its potential to affect adversely the Department's relationship with Dean House and the consequent flow of income from placements.

4.191 As a result of the staff communication to the Director, the Assistant Director of Residential and Day Care arranged to meet with the Governors in May, 1987. He was accompanied to that meeting by the Principal Officer for Children and the Assistant Principal Officer who already liaised with the home. At that meeting the Assistant Director stressed to the Governors the responsibilities which the Department had in regard to the continued registration of the establishment.

4.192 On 27 May, the Governors wrote to the Assistant Director requesting him "to conduct an independent inquiry on behalf of the Governors into the current staff relationships and problems of communication which exist at Dean House, with a view to providing recommendations to be discussed with a Sub Committee, possibly the Chairman and Vice-Chairman of the Trust." The Assistant Director instructed the Principal Officer for Children and the Assistant Principal Officer already involved in the home to conduct that inquiry. Their findings were incorporated into a report, a copy of which we have seen.

d. The Investigation leading to the Report

4.193 All staff were interviewed, but only two of the residents were invited for interview, and only one of them turned up. The residents were not told of the inquiry. It was presented to them as a routine inquiry to find out how they were getting on at Dean House. Whilst both the Assistant Principal Officer involved in the investigation and the then Director of Social Work believed that, in retrospect, more should have been done to involve the residents, the Principal Officer in charge of the investigation explained that this would not have been appropriate as the inquiry was focused, not on abuse, but on inadequate management practices and the drinking habits of the officer in charge. In any event, they already knew that the children viewed him unfavourably from the contents of the residents' meeting book. Even today, he doubted whether such an external inquiry by someone in a similar position would encourage children to talk about abuse.

4.194 The inquiry at Dean House also involved contact with social work area teams and the Emergency Duty Team, asking them to identify any concerns about Dean House.

e. Significant Findings of the Report

1. McLennan had been disciplined by the Governors in May 1987 for alcohol misuse. Staff had expressed concerns regarding him being under the influence of alcohol and driving

children when he had been drinking. (This last matter was also alluded to by former residents who spoke to us. The Governors deny ever having had prior knowledge of these allegations.) The Governors were advised as to the Department's Code of Guidance to assist staff who had problems relating to alcohol.

2. McLennan lacked judgement and the relevant professional abilities and qualifications for the post. The staff, including McLennan, lacked professional supervision. Staff rotas required to be improved. Too often, the officer in charge had to fill rota gaps.
3. Staff abilities and relationships suffered, not only from lack of professional support, but inadequate administration and office management, and lack of appropriate lines of communication to the Governors who were their employers.
4. Selection and employment procedures should be improved.
5. Specific conclusions were itemised and recommendations made. The recommendations focused on how the Governors might address the perceived deficiencies and how they could look to increase support from the Department's Assistant Principal Officer in doing so. Progress should be reviewed after six months.

f. Subsequent Events

4.195 The Governors communicated the terms of the report to McLennan who undertook to enrol for a CSS (Certificate of Social Studies) course. We have seen no record of his having accepted the other conclusions.

4.196 While the terms of the report were being communicated to him, a further incident occurred. On 3 October 1987, McLennan was absent from duty without permission. The matter was considered by the Governors on 15 October. They concluded, "after a great deal of discussion, after learning of this latest act of irresponsibility on the part of Mr McLennan, it was decided that he should be suspended on full pay until the beginning of January 1988 when he should commence the CSS course. He should also be warned that the Governors would not tolerate any misconduct on his part while on the course."

4.197 The matter was reported to the Assistant Principal Officer, along with further information indicating that, since the preparation of the report, further information had been received which commented adversely on McLennan's work performance. Legal advice was sought by the Assistant Principal Officer and thereafter he wrote to the Governors to the effect that "it would be very much open to question as to whether McLennan, as a person employed by the Governors, would be regarded as a "fit person" in terms of Section 62(3)(a) of the Social Work (Scotland) Act 1968." This Act gave the local authority power to cancel the registration of a person regarded as unfit. The Director of Social Work was to report to the relevant committee on 10 December, and the Assistant Principal Officer was required to draft a provisional report for the Director by 23 November. On 24 November, McLennan resigned.

g. Consequences of the Report

4.198 The Governors accepted the terms of the report. The Chairman of the Board indicated that there was some expectation, on her part at least, that the requirement to undergo training might lead to McLennan's departure as it was unlikely that he would successfully complete the course. This would be a preferable mode of departure to a disciplinary procedure which could involve financial payments if they took the wrong decision.

4.199 The Board implemented a number of the recommendations, particularly with regard to improved staff rotas and supervision.

h. Conclusions

4.200 The Report did not consider allegations of abuse. However, it did relate to care issues for children in Dean House which obtained over a long period and included the time when abuse took place. The Assistant Principal Officer who was the Department's link with Dean House has asked us to make it clear that there was no suggestion that he was in any way aware, during his involvement with Dean House, of the behaviour and criminal acts of which McLennan was subsequently convicted. We are happy to confirm our acceptance of that.

4.201 Whilst we recognise that for safe child care it is essential to establish an appropriate work and staff structure, too much focus in the report was given to that element without considering the impact that deficiencies were actually having on the residents.

4.202 The terms of the report supported the staff perception that they had experienced difficulty in communicating their concerns. The only real means of communication that they had was through the officer in charge, in whom they had by then lost confidence. He was very much "the Boss." He did not communicate well with them. Similarly, our perception is that the children had difficulty in communicating with staff. They appear to have tried to express their dissatisfaction, particularly with regard to McLennan's drinking. This is of particular relevance given that many of them had been removed from families in which alcohol abuse was a feature. The Board members believed that their own regular presence in the home meant that they were available to be approached by residents and staff. However, the reality seems to have been that both residents and staff saw the Board as distant persons.

4.203 It seemed that, when McLennan's involvement with alcohol was identified, the focus of the Board, following Social Work Department policy, was on supporting the staff member. This detracted from consideration of the detrimental effect it must have had upon the children. McLennan's inappropriate behaviour in front of officials from the Social Work Department was of concern because of the impact that might have on the attitude of those responsible for placing children, at a period when there was concern about the sufficiency of numbers to keep the home economically viable, rather than because of the effect it might have on the children. There seems generally to have been a lack of awareness of the impact upon the children of bad management and bad behaviour by staff.

4.204 However, we feel it is only fair to mention at this point that there were a number of other factors which obtained at Dean House which very much impressed us. For example, the Governors arranged that volunteers from their own number or from the community would help children with homework. A negative feature for many children looked after by local authorities relates to their falling behind educationally. The support provided in this way for children was appreciated by at least some of those who spoke to us, and we considered it a practical and highly appropriate support for the residents. Similarly, as regards employment practices, Dean House was ahead of its time in recruiting staff on a provisional basis, subject to satisfactory performance. This was long before the Social Work Department even thought about probationary periods of employment. The Chair of the Board at the time of McLennan's

resignation also told us of her frustration at the lack of success of her repeated attempts to obtain facilities for checking the criminal records of successful job applicants.

i. The Provision of References for McLennan

4.205 In the course of our Inquiry we learned that at least two persons had given references to Mr McLennan before and after his resignation from Dean House.

1. The APO's Reference

4.206 On 16 July, 1987, the Assistant Principal Officer who was at that time actively involved in the preparation of the report relating to Dean House, furnished a written reference for McLennan to a care organisation for “mentally handicapped people” in Leicester. This was written on Lothian Regional Council notepaper from his position as Assistant Principal Officer for Children. Despite the fact that the writer of the reference was then already participating in a two man team which went on to make serious criticisms of McLennan and his ability, there is not one adverse comment in the reference. It recounted that it was written on the basis of the writer's knowledge from “the last two years in my professional capacity as local authority registration/inspection officer for voluntary children's units.” Positive comments include, “Brian has a realistic perspective on management issues and provides clear leadership to his staff group.... His experience and maturity would provide a valuable staff input into the care of residents,” and that, “as a deputy manager, Brian would also provide the necessary support to the manager.” The reference also includes the comment, “While I know Dean House would lose a great deal with his departure....” Some two months later, the author of the reference was actively involved in writing reports indicating the deficiencies of the manager. By that time, Dean House and those who managed it looked forward to the “departure.”

4.207 The Assistant Principal Officer now regrets having written the reference. He suggests that he was influenced by the fact that the post for which the reference was required was one of depute rather than officer in charge. He was also influenced, he believes, by the fact that the application was for a post dealing with people with learning difficulties; an area in which he understood the applicant to have had previous experience. He indicated that, whilst he cannot now recall with whom he consulted, he believes that he would have consulted one of his line managers about the reference.

4.208 The then Principal Officer for Children, Assistant Director, Residential & Day Care and the Director of Social Work all denied knowledge of the reference. The then Director of Social Work deplored his former member of staff's action. He did not believe that, at the time, the writing of the reference would have been contrary to generally issued departmental instructions, though he did subsequently introduce a requirement that any reference other than a personal one could be supplied only by an officer of Assistant Director level or above. Further, in the light of the contents of the report, which was then under preparation, he thought that the issuing of the reference was particularly irresponsible. The then Assistant Director, Residential & Day Care denied any personal knowledge of the reference and expressed himself “flabbergasted” that such a reference had been provided at that time. The then Principal Officer for Children also declared himself “astounded” at this action.

4.209 We have little difficulty in adopting the clear view of the then Director of Social Work. We believe that the issuing of what the author must have known to be an incomplete and misleading reference was irresponsible.

4.210 Those who seek and obtain references are entitled to rely on what is written as giving an accurate assessment of a candidate's ability. References provide an appropriate method to assist appointment of suitable staff. For vulnerable clients, including the "mentally handicapped" or children, accurate information from references is of critical importance. It has been suggested to us during the course of our work that provision of a positive reference for an unsatisfactory member of staff was at that time, and possibly still is, a convenient way of solving a staffing problem for the author. We recognise that, in situations of this kind, without any departmental protocol to bar the giving of references by a particular level of staff, it might be difficult to say no to a request for a reference, and that it is easier to make positive rather than critical statements. In the course of our inquiry we had been advised by more than one source that McLennan and the Assistant Principal Officer were friends. The Assistant Principal Officer specifically denied to us that he had any social contact with McLennan, and insisted that their association was restricted to his professional association with him. He indicated that that was on a friendly basis, which mirrored his professional approach to the work. We accept that, particularly in relation to provision of support and supervision for a voluntary organisation, a friendly approach would be understandable.

2. The Chairman of the Board's Reference

4.211 The Chairman of the Board at the time of McLennan's resignation, told us she had responded to a request from a residential home in Northumberland for a reference for him. She believed that she had given an honest and fair description and invited the recipient to get in touch with her for further information if required. We have not seen that reference. Although written on Dean House paper, we have been unable to trace a copy. Because of his previous experience in Australia, she believed that McLennan would be better placed working with the "mentally handicapped" than with the older children who were by then being placed in Dean House. There had been a sense that McLennan's difficulties lay partly in his inability to adapt to the changing population of residential child care and the increased age of residents. She had encouraged him to apply for a post in England in a field in which he had previously worked. McLennan himself had expressed to staff a wish to remove himself from working with older children.

j. Conclusions

4.212 The Provision of a reference by the Assistant Principal Officer was wholly inappropriate. As we have not seen the reference provided by the Chair of the Board, we could not make the same comment. In any event, it was provided on a different basis. We make the obvious recommendation that persons who provide references should do so with total accuracy and comment on strengths and weaknesses so that recipients, particularly where applicants will be working with vulnerable persons, can rely on their accuracy.

Lesson 69: Management problems were the focus of concern with both Knott and McLennan.

Lesson 70: There is a need to have proper “whistle-blowing” procedures to ensure that staff are listened to.

Lesson 71: Consideration should always be given to the advantages that might be gained by taking account of the views of residents when investigations are being undertaken within residential units.

Lesson 72: There is a danger of over-emphasising the needs and rights of employees at the expense of the children.

Lesson 73: It can be tempting to give good references as a useful way of relieving oneself of unwanted staff.

k. The Role of the Social Work Committee

4.213 Social Work Committee minutes confirm that no reports of abuse of children in residential care were reported to the Committee. This might have been a possibility in respect of three of those “reports made” at the time of the abuse which had been subject to some level of investigation. Glenallan Report 1 was investigated within the unit, resulting in the allegation being withdrawn. It was not reported to the Directorate and therefore never became known to the Social Work Committee. Dean House Report 2, made in 1981, was reported up to the level of the Assistant Principal Officer within the Residential & Day Care Section. It did not proceed to the Directorate and therefore was not reported to the Social Work Committee. Dean House Report 7, made in 1982, was reported to the Divisional Officer with responsibility for fieldwork. It was not reported to the Social Work Committee.

4.214 A further contemporary report, Dean House Report 10, was also subject to investigation. It was not reported to the Social Work Committee, although the then Director of Social Work was able to retrieve from his personal records a note of a meeting of 8 June, 1987, in which he had informed the Chair of the Social Work Committee of a report being prepared on behalf of the managers of Dean House. He had also indicated that the Social Work Committee representative on the Board at that time wanted briefed on the matter. On October 26, 1987, he had told the Chair about work done with the Governor, by which time McLennan had been suspended. As indicated above, however, there is no evidence that the concerns about McLennan at that time related to abuse of children.

4.215 We make no adverse comment on the fact that these reports were not made available to the Social Work Committee. Individual allegations might reasonably be felt to fall within the province of professional staff, with the added external safeguards already discussed in this report. The Committee itself would be concerned more with the general safety of the facilities which it provided or supported for the care of children. This was the case with Dean House Report 10, which was reported to the Chair of the Social Work Committee and which would have come before them with reference to the registration of that facility and the fitness of the person in charge of it.

4.216 There remains an issue about the expectations which might reasonably be made of the local authority representatives appointed to the Board of Dean House and other outside bodies. The representatives on the Board at that time have indicated that they knew nothing of the allegations investigated in relation to Child N in 1981 or Child P in 1982. Board minutes show that a representative of the authority was present at a meeting of the Board of Governors

when the conclusion of the investigation regarding Child N was reported. She has no personal recollection of the matter and indicated to us that, from the content of the minute which we showed to her, she would have concluded that the matter had been dealt with and was concluded. The report of Child P was never formally communicated to the Board. We make no adverse comment about the actions of the local authority representatives on the Dean House Board. However, it is our view that it should in future be made clear to representatives serving on outside bodies what the purpose of their appointment is and what the authority expects of them in that connection.

Lesson 74: The roles and responsibilities of local authority representatives on the Dean House Board of Governors were not clear.

X. Dean House Behaviour 1 - Children made comments about McLennan

a. The Behaviour

4.217 R, who had been resident in the home and gave evidence at the trial, told us how children made sarcastic comments about McLennan and tended, while talking about him, to use the name "Pervy Brian." They did not use that name directly to him. The member of staff to whom we spoke did not recall the use of that phrase, but she did remember the children expressing dislike of the officer in charge. She commented: "We really didn't think anything about it."

4.218 R herself accepted the reason for staff's failure to respond. She said that name-calling and the use of words like "poof," was a commonly understood way of children expressing their anger at staff. Another former resident of Dean House told us about experiences in another unit where they used the term "beast" about a member of staff there, adopting knowingly the commonly pejorative expression for adults who commit sexual offences. The use of "Pervy Brian" mirrored the expression used at Clerwood in respect of McLennan. It is possible that the network of children in care may have prompted the transfer of the nickname between units, but it is equally, if not more likely, to have arisen from the experience at Dean House only.

b. Conclusions

4.219 We make no criticism of the staff for failing to respond to such expressions as were used of McLennan. Children in residential units will get angry with staff, possibly with senior staff members. That anger may reflect their simple non-acceptance of decisions which are essential for their own interests and safety. We recommend however that staff continue to recognise that children may in this way be expressing hidden concerns, and children should be questioned and counselled sensitively regarding such terminology.

Lesson 75: In Dean House children called McLennan a Perv.

Y. The Report that Led to the High Court Trial

4.220 Having considered reports and behaviours which were either not responded to or only partially so, it seems to us that we should also present how the case eventually came to light.

4.221 In 1996, G met a member of the Social Work staff who was and is currently working in a children's centre in Edinburgh. When G was resident in Glenallan, that member of staff had been working there as a residential care worker. G and the member of staff had been on good terms.

4.222 The member of staff and G chatted about his time in Glenallan. There is some disagreement as to how the allegations G had originally made to the criminal justice worker were raised again by him to this member of staff.

4.223 G claims that the member of staff asked him to put his mind at ease by telling him whether or not there had been anything untoward going on between him and Gordon Knott. He said it was in response to this request that he had told him of the abuse. The member of staff denies this. He says that the matter arose because G was concerned about the possibility of his own children, or other relatives, being received into care, and their safety if that happened. He said it was this concern on G's part that had prompted him to tell of the abuse. Whichever way it arose, the member of staff then dealt with the matter promptly and appropriately by referring it to the District Manager. The District Manager dealt with the matter appropriately by raising it with the police. The police dealt with the enquiry very appropriately.

4.224 A huge enquiry was instituted. Initially, that enquiry related to G and then extended to other residents at Glenallan. When it transpired that Knott had been employed earlier at Clerwood, the investigation was extended to former residents of Clerwood. Some of these residents spoke about McLennan. When it was understood that McLennan had moved on to Dean House, enquiries were made of former residents of Dean House.

4.225 The Social Work Department supported G and the other witnesses very appropriately throughout the enquiry. Not all of the witnesses were originally well disposed towards the Social Work Department staff. Much support was provided by the Children's Rights Officer and, during the court proceedings, by the dedicated staff at the High Court office. The witnesses valued this support.

4.226 A feature of their information to us was their appreciation of the way in which the police carried out their enquiries. It appears that these painstaking enquiries were carried out with great sensitivity. Considerable time was allowed to witnesses to give the information. They were allowed to proceed at their own pace. Almost invariably, the witnesses, some of whom had not previously been well disposed to the police, sensed sympathy and understanding from them. The police officer in charge of the inquiry displayed rigour and zeal and commitment to the task. He and his officers are to be warmly commended for the way in which they conducted their enquiries and brought the accused to justice. Without that high degree of commitment, these grave offences would have gone unpunished and there would have been no recognition of the abuse perpetrated on former residents.

Z. Summary of Themes Arising from the Past

Isolation

4.227 Despite the existence of some outside links, the homes were experienced by the children as self-contained with a lack of significant outside supervision or involvement. The officer in charge was very much “the boss” and was not perceived by residents as being accountable to anyone else.

4.228 In Dean House, the officer in charge did in fact concentrate a lot of authority within himself, thus disempowering other staff. Senior staff were often young and/or inexperienced or untrained.

4.229 Recruitment practices were generally poor. McLennan was able to move from one job to another on the basis of references which were less than open and honest.

4.230 Neither field social workers nor children’s hearings were experienced by the children as external safeguards.

Appearance of happiness

4.231 To the outside world, both Glenallan and Dean House appeared to be happy places. In particular, Gordon Knott was liked by the children. This suggests a very real difficulty in recruitment of child care staff in respect that many of the desirable qualities of such staff, in terms of empathy with children, can also be a screen for abuse.

Why they did not tell

4.232 The abuse often started when the children were too young to realise it was wrong. It sometimes seemed to the children that other staff must have known what was going on. They were reluctant to tell about the abuse because they felt no-one would believe them. They felt stigmatised by being in care. They felt others thought they were in care because they had been bad. They would not even tell people they liked, because they were afraid of the consequences. They might be moved somewhere worse, or things might just get worse in the Unit.

4.233 Children’s most tender feelings were exploited. In some cases the child experienced the abuser as a father figure and was encouraged to do so. In other cases concern for their relationship with siblings, and threats about splitting them up, kept children from telling.

4.234 The children did not generally discuss the abuse with each other. It was experienced as a private matter. However, there was often a common, unarticulated understanding which manifested in group activity such as name-calling and repeated patterns of behaviour.

Picking up signs

4.235 Adults did not pick up the children’s signs: group name-calling, self-harm and running away. Where staff had concerns, about bad management (which was an issue as

regards both Knott and McLennan), they were unable to communicate these effectively to external managers or Governors. External managers did not pick up the staff's signs.

Lack of awareness

4.236 There was little awareness at the time that adults could indulge in sexually abusive behaviour. This lack of awareness, and difficulties in articulating and raising issues, would have made it all the more difficult for children to talk about abuse, and difficult for the adults to believe what reports were made or to identify the signs given out by the children's behaviour.

Responsibility and accountability

4.237 The allocations of responsibilities was not clear. Dean House ran on goodwill and trust with no clear allocation of responsibility or accountability. Within the Social Work Department, there was said to be a lot of autonomy at all levels. Workers lower down the scale do not seem to have passed information to their superiors in situations where this might have been deemed appropriate. The officer acting as a link between the department and Dean House was unclear about his own remit.

Contemporary reports

4.238 The retraction extracted from Child G after his posting of a letter under the door shows the necessity of maintaining a record even of withdrawn allegations. Children may retract for a number of reasons. It is important that sufficient information is available to allow any patterns to be identified, or incidents to be picked up if they are reported again later.

4.239 In the case of Child N, the person she reported abuse to was her mother, who was perceived as a difficult person bearing a grudge against Dean House. It is important to acknowledge that parents perceived as inadequate or difficult might still be the people the child trusts most and will report concerns to.

4.240 Child P's interview in the Boardroom of Dean House was likely to have been an intimidating experience, and not likely to encourage him to persist in telling the full story.

4.241 Employment law and the policy focus on supporting adults with alcohol difficulties moved the focus inappropriately from the needs of the children to the needs and rights of the adult employees.

4.242 Education staff responded in different ways to the situation of the children. It is important they are made fully aware of their responsibilities with regard to child protection.

4.243 Reports from children with learning difficulties should not be discounted because of the impact of those disabilities.

Later reports

4.244 Many of the children tried repeatedly to tell about the abuse later in life. The adults they spoke to either did not realise the significance of what was being said to them, or did not know how to respond appropriately. It should be acknowledged that former residents who have had involvement with the police due to offending behaviour may express a reluctance to report abuse to them. This should not be interpreted as indicating that the report is not true.

4.245 There is a clear need for guidelines on responding to allegations of historic abuse. In particular, social workers in criminal justice and community care teams may be the recipients of reports of historic abuse and need to know how to progress them.

4.246 Where reports were picked up and acted upon, considerable difficulties were caused in some cases by the departure of members of staff leaving tasks and records incomplete.

4.247 The reasons for discontinuing an investigation, on the part of the police or the Social Work Department, should be recorded.

4.248 The investigation which led to the trial was characterised by prompt action by the worker receiving the report and a police investigation which, the victims repeatedly told us, proceeded at their pace.

AA. Conclusions

4.249 It is clear from the above that, over the years, many of the former residents of Clerwood, Glenallan and Dean House, have tried to tell about what happened to them. Sometimes they have done so very explicitly, at other times more tentatively. From their childhood in these homes, their behaviour has also pointed to the abuse which they were suffering, again sometimes more explicitly than others. In later life, many have been consciously aware of the long lasting impact upon them of their childhood experiences. For some, a need to exorcise this has been one of the catalysts for telling of the abuse. Some have also been brought to the position of making reports by their adult concerns for their own children, or for other children who might find themselves in a similarly vulnerable situation. Many have also experienced a need for justice to be done; for the tables to be very publicly turned upon those who exerted, and abused, such power over them.

4.250 We cannot claim that the reports and behaviours we have set out above tell the complete story. We believe we have addressed those that were in the public domain following the High Court trial. Through the process of our inquiry we have also discovered more reports than were previously indicated. However, it seems to us likely that some at least of those former residents who did not accept our invitation to speak to us have other stories to tell. We believe it would have been a further abuse to have compelled them to speak with us, and that nothing would have been gained by doing so.

4.251 Having met with many of the victims of the abuse by Knott and McLennan, we are very aware of the emotional pain involved in repeating their stories to us and in witnessing yet another round of public debate about events that were experienced by them as very private

and individual hurts. We owe an enormous debt of gratitude to them for their co-operation with our report.

4.252 For staff and management too, the setting up of the Inquiry and the recalling of memories in the light of the revelations about the abuse has been a painful experience. Many have told us how they have gone over matters in their minds repeatedly and tried to identify whether there was anything they could or should have done to identify and stop the abuse. As one former member of staff commented: “At the end of the day, I wish we could get together with these kids and say, We’re really sorry we let you down.”

5. INTERVENING EVENTS

A. Receipt of Anonymous Letter and Associated Allegations

5.1 On 10 February, 1998, a number of recipients, including the Inquiry Team, received an unsigned letter purporting to have been written by “a group of City of Edinburgh Council employees.” It claimed:

1. Management had covered up and hidden evidence relating to other reported cases of abuse of children in care in Edinburgh and the Lothians.
2. They themselves were aware that “certain managers” had not followed up complaints and continued to cover up corruption and abuse of children in care.
3. The “Care and Control” policy document was “seen to be a paper exercise” and “considered as a joke” by many staff.
4. The conditions that had allowed past abuse to occur had not changed because the same personnel were still in positions of power.
5. Staff who had had the courage to complain had been ignored and sometimes victimised and harassed.
6. Cruachan and Redhall were cited as examples of units in which abuse had been reported. It was alleged that the perpetrators had friends within the police service, with possible Masonic connections, and that this had influenced the fact that the police investigations had resulted in no charges being made. It was alleged that social work managers were complicit in the “cover up.” Two were named. One had left the Council’s employment. The other was still a senior manager in Edinburgh.
7. It was alleged that staff working under this senior manager “feel unable to complain as they know [the manager] will not listen or will hide concerns.”
8. It was alleged that “Employees feel therefore that they are still unable to speak out about past and present abuse in residential units as the abusers are seen to be protected and even rewarded.”
9. The letter ended with a call for a “full and neutral Police inquiry into the appalling Cruachan situation. Hopefully this will lead to a Public Inquiry.”
10. The writers concluded: “Once we feel safe we are sure many employees will speak out.”

B. The Director of Social Work’s Response to the Letter

5.2 These were clearly very serious allegations which aroused a great deal of interest in the media. The Director of Social Work responded by:

1. passing a copy of the letter to the police “at the highest level” for consideration of the allegations relating to the two children’s units: Cruachan and Redhall;
2. asking the senior manager named in the letter to take voluntary leave of absence to allow the matter to be investigated;
3. enquiring into the employment history and current whereabouts of the other manager named, who had left the Council’s employment; and
4. asking this Inquiry to consider including in its remit an investigation of the allegations contained in the letter.

C. The Inquiry's Response to the Letter

5.3 We were of the view that some of the allegations contained in the anonymous letter clearly fell within our remit, in respect that they alleged that conditions conducive to abuse of children looked after by the Council still existed. With regard to the specific allegations about past abuse, we considered it would not be appropriate for the Inquiry to duplicate the role of the police who had been given a copy of the letter and were making their own investigations. Further, as indicated in Chapter 2, we had identified our own form of procedure on the basis that criminal processes had already established that abuse had taken place. We had therefore felt able to adopt a more informal approach, taking as our main focus the lessons to be learned from the past and the safety of children currently looked after by the Council. The situation was different as regards Cruachan and Redhall. It had not been established that abuse had taken place. Had that been our remit, our approach to that inquiry would have been different. However, given that we were already committed to visiting residential units and listening to staff and residents, this presented an opportunity for anyone with information about abuse or about difficulties in communicating concerns to senior management, to come forward.

5.4 Our own involvement was therefore based upon two considerations:

- the action the Social Work Department might have taken to test out the allegations seemed to duplicate what we already intended doing as part of the audit of current safeguards; and
- the concerns expressed about the possibility of a departmental cover-up made it more appropriate for the Inquiry to undertake the task rather than the Department.

5.5 Our interest was in the possibility of “cover-ups” in the past or blocks to pursuing allegations in the present. The truth or otherwise of the allegations about the abusive incidents themselves was something we could look at and indeed form an opinion on. However, we were not in a position to carry out a thorough investigation into the truth of every allegation that was made, particularly as the emergence of fresh allegations was a regular occurrence.

5.6 Accordingly, we encouraged those coming to us to tell their stories to the police, and to the Social Work Department where that seemed appropriate. In some instances we ourselves communicated with the police to facilitate their enquiries.

5.7 In order to further encourage the writers of the letter, and anyone else with concerns, to do this, we:

1. set up a confidential Post Office Box with an assurance that mail sent to it would be uplifted personally by members of the Inquiry team; and
2. arranged for information about the Inquiry's remit, and how to communicate with it, to be sent individually to all relevant members of social work staff in Edinburgh and the Lothians. It was seen as important to extend the invitation to the Lothians because of their historical association through the former Lothian Region and the mobility of staff between these areas.

5.8 The concerns addressed by us fell into three categories:

- the allegations about the named senior manager who was still employed by the Council;
- the concerns about the efficacy of current safeguards for looked after children; and
- allegations about specific units.

a. The Senior Manager on Leave of Absence

5.9 The Inquiry team undertook to give priority to interviews and visits having a bearing on the allegations in the letter. The situation of the senior manager who had stepped aside was clearly a cause for concern. On the one hand, the manager's leave of absence, which was "voluntary" but about which he felt he had little choice, was seen as an act of good faith designed to assure the authors of the letter that their allegations were being taken seriously, and to remove what they had said was a barrier to them coming forward. On the other hand, even apart from the feelings of the manager involved, staff anxiety was already high as a result of the High Court case and the setting up of the Inquiry. It would not have been conducive to staff morale had there been any suspicions of a "witch hunt" based upon anonymous allegations. This could also have had a knock-on effect on the quality of care experienced by the children and young people looked after by them.

5.10 Our visits and interviews disclosed no further concerns about the senior manager involved. On the contrary, many staff wrote to us expressing their confidence in the manager and their own experience of that person as someone who was approachable and who took their concerns seriously. The authors of the letter did not come forward to identify themselves or to present any further information to support their allegations. The manager returned to work after an absence of approximately six weeks.

b. Current Safeguards

5.11 Those concerns expressed in the letter about current practices and procedures with regard to reporting abuse will be considered later in this report in the context of the Inquiry's audit of current safeguards, with particular reference to the policy on "whistle blowing."

c. Allegations Involving Specific Units

5.12 The anonymous letter had named Cruachan and Redhall as the location of past abuses. In the wake of the publicity about the letter, other allegations surfaced about a facility at Chester Street. We also received allegations about past events in a number of other units. Some were subsequently withdrawn, and others were based on hearsay. Some did cause us particular concern.

5.13 On receipt of the anonymous letter, the allegations about Cruachan, Redhall and Chester Street were investigated by the police. On 18 March, 1998, they reported that they had completed their inquiries and indicated that the Procurator Fiscal had decided that, at this time, "there was no basis for criminal proceedings against any individual."

5.14 Bearing in mind the discussion in Chapter 2 about the different aims and standards of proof in criminal and child protection processes, the decision of the Procurator Fiscal not to prosecute should not be interpreted as absolving the Department from the responsibility of considering whether it ought itself to investigate with a view to identifying whether there

exists a level of concern sufficient to warrant action to safeguard children. In the criminal sphere, a very high standard of proof is required to justify a conviction. Evidence that might not meet this high standard of “beyond reasonable doubt” might nevertheless satisfy the less demanding “balance of probabilities” which applies in civil matters, including child protection. We therefore set out the results of our own restricted enquiries.

D. Specific Allegations

5.15 We describe here some of the concerns raised and our response to them, and we draw conclusions about those aspects relevant to our own remit:

- Were there legitimate concerns about abusive practices?
- Was there a cover-up in the past in relation to allegations made?
- What lessons can be learned for the future?

a. Cruachan

5.16 Cruachan was a residential unit which closed in 1992. The anonymous letter said that staff and children had complained since the early 1980s about physical, emotional and sexual abuse. It was suggested in the letter that investigation had been inadequate and hampered by a Masonic connection. No charges had been brought. Some of the staff implicated were said to have been moved to other posts with vulnerable young people.

5.17 Our enquiries showed that concerns about Cruachan had been investigated by the Social Work Department in 1989. The decision to initiate the investigation had been prompted by complaints by two members of the Cruachan staff and one former temporary member of staff. These related to allegations against three named members of staff as well as more general management and practice issues. The allegations against particular staff members focused on inappropriate comments to other staff and residents, drinking on duty and slapping and hitting residents, which was explained by the member of staff involved as having been done in a playful way. The more serious allegations referred to only one of the three staff members. The report noted that the absence of clear practice guidelines on these matters made it problematic to consider any disciplinary action.

5.18 More general matters addressed included the lack of a consistent approach to staff supervision and, what was described as “a critical area”, the use of sanctions within the unit. These included: stopping home visits; keeping residents in their pyjamas, sometimes involving the forcible removal of clothes; and residents being confined to their rooms for several days. It was confirmed that this was regarded as acceptable practice by the staff within the unit and was known to field social workers and management. The report recommended:

1. That the putting of young people into pyjamas ceases, with written instructions from the Directorate.
2. Following on from this, keeping of young people in their rooms for long periods (days), is dealt with in the same way.
3. That the forcible removal of clothes is forbidden – bearing in mind that this action is an assault and indeed could be construed as abusive.
4. That the stopping of home visits to families is reviewed as a sanction, and a general policy is developed to reflect the Department view of this practice.

5. That clear and concise Practice Guidelines are developed – incorporating what the Department will and what the Department won't accept in relation to sanctions.
6. Sensitive and considered work with the Staff Team to generate an alternative ethos to dealing with difficult behaviour in keeping with the outcome of 5 above.

5.19 The Report also noted that staff had difficulties dealing with issues relating to sexuality and had little awareness of reporting procedures in response to concerns about sexual abuse. It was recommended that training in these issues should be provided.

5.20 A second investigation was initiated in 1992, shortly after the closure of Cruachan, when a former resident who had moved to another unit alleged that at Cruachan she had been slapped, her clothing forcibly removed, and that she had been detained in her room for a week, wearing her nightdress. These incidents had taken place after the conclusion of the 1989 investigation. We obtained an "Interim Summary of Findings" prepared by an officer from the department (presumably in 1992, although the report is unsigned and undated) which observed:

At present there are a number of concerning findings from my investigation into Cruachan and its practices with young people. Those findings are all the more concerning given that I conducted a detailed investigation into this Unit 3 years ago and that the Department since that time has issued a Care and Control Document outlining clearly the practices which should not take place.

5.21 In addition to the concerns already referred to, it was alleged that there was sexual counselling of the children which might be inappropriate, strip-searching, and examination of a male resident's genitals to ascertain his stage of physical development.

5.22 The 1992 allegations were also investigated by the police. It would appear that the social work investigation was suspended while the police were involved. The police reported to the Procurator Fiscal who decided that no further action would be taken by his office. It was indicated that this decision had been reached only after most careful consideration as in some of the allegations it was possible to see in them an element of criminal activity depending on the circumstances in which the act occurred. We were told that the police view at that time was that, if the 1989 recommendations had been acted upon, the later concerns would not have arisen.

5.23 The matter was therefore returned to the department for consideration in terms of their own procedures. The then Principal Officer for Children and Young People had recommended that the Department proceed with its own investigation after the conclusion of the police investigation and whether or not it resulted in criminal proceedings. However, the then Director of Social Work decided against this course of action. Correspondence which we have seen indicates that staff were to be told that, on the basis of the decision of the Procurator Fiscal to take no further action, no further action would be taken within the Department. His thinking is outlined in a letter to a member of staff indicating:

In view of the fact that Cruachan is now closed and that some members of staff have retired and others have been redeployed to other units I feel confident that I can rely on the present guidelines of practice to ensure that proper standards of child care within our service are maintained.

5.24 Both the 1989 and 1992 internal social work investigations had been carried out by the senior manager named in the anonymous letter who no longer works for the department. As indicated above, we were unable to trace the current whereabouts of this former manager.

5.25 Our concerns about Cruachan were that:

- The 1989 internal investigation had resulted in a number of recommendations about future practice;
- Nevertheless, the incidents leading to the 1992 investigation showed similar concerns about bad or, at the very least, inappropriate, practice. This was not addressed by any disciplinary processes.
- The 1992 internal investigation was very limited. It was not resumed at the conclusion of the police investigation, despite the strong recommendation of the Principal Officer for Children and Young People.
- The lack of any formal follow-up by the Department meant that there was little to record the concerns about the members of staff involved. Of the two staff members mainly implicated, we are aware that one retired prior to the closure of Cruachan. The other resigned shortly thereafter.

5.26 In addition to the allegations in the anonymous letter, we received information naming three ex-residents in respect of whom abuse at Cruachan was alleged or suspected. Also, two former members of staff told us about concerns they had expressed at the time about inappropriate behaviour by other staff members. Both indicated that they had reported these to the senior manager who conducted the investigations. Both said they had submitted written reports to him, but neither had kept a copy and there was no record of them in the information made available to us. The senior manager involved was reported to us as having been disorganised. That said, all of the information which we have received would demonstrate very clearly that he was never a part of any cover-up or that he was rewarded for not taking action.

b. Redhall

5.27 Redhall had been named in the anonymous letter as a unit where abuse had taken place and been reported to no effect. However, no details were included in the letter.

5.28 Redhall had closed in 1984. Our contact with the police disclosed that allegations about Redhall had been investigated at the same time as Cruachan in 1992. A report had gone to the Assistant Procurator Fiscal, who had marked it “no proceedings.”

5.29 It does not appear that concerns about Redhall were ever investigated to the same extent as Cruachan. In addition to the 1992 investigation, we are aware of one further internal investigation of a particular concern which concluded that no inappropriate activity had taken place.

5.30 Apart from the general reference in the anonymous letter, concerns about Redhall were expressed to us by a former resident who claimed to have been abused, and by one current and one former employee of the department.

5.31 Concerns centred on two former staff members. One of these was the person named in connection with Cruachan who had since retired. The other still worked with young people in a different capacity.

5.32 We encouraged those who came to us to contact the police about these concerns. We also contacted the police ourselves to ensure that they were in possession of any significant information which had been provided to us. This does not imply that we uncovered substantial further information which would encourage them to re-open their own inquiry. We have in addition passed relevant information to the employer of the person still working with young people.

5.33 It came to our attention that one of the members of staff implicated had subsequently given a reference for a resident which contained no mention of the fact that her relationship to him had been as a client. We consider this to be inappropriate and we take account of it later in our report with regard to the provision of references.

Lesson 76: Members of staff should not give references for clients which omit any mention of the nature of their relationship, even if that is now in the past.

c. Chester Street

5.34 Following the publicity about the anonymous letter, two former residents of the Chester Street hostel contacted the Social Work Department alleging inappropriate behaviour by staff from 1981 to 1986. This was said to have involved drugs, drink, political activity and a degree of sexual harassment. Three former residents contacted us to deny such allegations and to speak highly of their care whilst there.

5.35 The allegations were investigated by the police, but no criminal charges followed. The Social Work Department has also undertaken extensive investigations which have been concluded in terms of their own procedures. We are aware that there have been concerns amongst staff about the duration of suspension of staff pending the investigation. This is relevant to our consideration of investigation processes which is discussed later in this report.

d. Other Allegations

5.36 As the Inquiry progressed, allegations were received with regard to other residential units. Three involved allegations of abuse by staff and problems encountered when these concerns were reported. One concerned an allegation of abuse by other residents. The allegation that was potentially the most serious was reported to us by the Department which had itself taken the matter very seriously. The allegation itself was based upon hearsay with a considerable degree of remoteness, and the person who was identified as its source was said to be now living abroad. We eventually managed to contact this person who was unable to give us any further specific information. Such information as we had was passed to the police, although we are not aware of any further formal investigation.

5.37 Of the other allegations, one was subsequently retracted and the others were already known to the Department and being progressed by them.

E. Conclusion

a. Were there legitimate concerns about abusive practices?

5.38 Many people have told us how the culture of residential care has changed over the past decades. Some things that would no longer be regarded as acceptable were once tolerated, if not approved of. For example, some staff of the Emergency Social Work Services Team in Edinburgh sent us a paper entitled “Lothian Children’s Homes in the 1980s.” Its aim was “to reflect the knowledge that Emergency Duty Team staff had of the operation of Children’s Homes in the 1980s.” An extract from this report has already been set out at the end of Chapter 3. The report stated:

A form of “pin down” was widely used in the 1980s. Children, either for punishment or because it was thought they would abscond, would be kept in their night-clothes, without shoes and isolated in their bedrooms. The department’s report after the Staffordshire pin down enquiry did not highlight this as a problem.

5.39 The Staffordshire Inquiry referred to had reported in 1991 upon the inappropriate use of control measures in children’s homes, including deprivation of liberty and social isolation.

5.40 Even granted that the culture has changed, on the basis of the voluminous papers which we have read, we are left with great concerns about the past allegations with regard to Cruachan and Redhall. These papers indicate that there have been repeated patterns of behaviour associated with the same names over a significant period of time.

5.41 We recognise that there is considerable unease amongst staff about the consequences of being the subject of false allegations. After an initial protective response which may involve suspension from duty, there are huge practical and evidential obstacles to be overcome before allegations can be established to the extent required for disciplinary or child protection measures. This matter is considered in today’s context in Chapter 10 of this report in the context of investigation.

5.42 On the basis of the information presented to us we are left in little doubt that the concerns about abusive practices were legitimate.

b. Was there a cover-up in the past in relation to these allegations?

5.43 The Departmental report of the 1989 internal investigation refers to suspicions by two staff members that a group of officers in charge had untoward influence on senior management and were being protected by someone senior within the Department. The report concluded that there was no evidence to substantiate this. However, it recommended the introduction of clear and precise procedures for investigations which should always involve the Employee Relations staff, and the establishment of an independent inspectorate.

5.44 Similarly, whilst the text of the anonymous letter of 1998 demonstrates that these concerns about “cover-ups” still exist, we have found no evidence that would lead us to conclude that there was a deliberate cover-up with regard to the allegations that have concerned us. Although the then Director did not initiate a Departmental investigation in 1992, he explained the basis for his decision as being his knowledge that the units involved

had been closed and staff moved on. This is not an unusual sequence of events when managers have concerns which they feel unable to establish. The clear view of the Principal officer for Children and Young People was that an independent Departmental investigation should take place. We adopt that view. The allegations against some staff members should have been investigated, not just for reasons of justice for the victims, but to establish whether the persons concerned should be allowed to continue working with children. However, we do not believe that this was a deliberate cover-up.

5.45 There is no doubt that the consequences of the lack of an effective Departmental investigation of the concerns about Cruachan and Redhall is still reverberating within the Department. The authors of the anonymous letter which drew our attention to these concerns called for a “full and neutral Police inquiry into the appalling Cruachan situation. Hopefully this will lead to a Public Inquiry.” The police have made further inquiries and the Procurator Fiscal has decided that there is no basis for criminal proceedings. The question remains whether a further Departmental or public inquiry focusing specifically on these allegations would now be beneficial.

5.46 We would not suggest that the passage of time is in itself a reason for not initiating a further inquiry. However, the Cruachan situation has now been the subject of two police investigations, two decisions by the Procurator Fiscal to take no action and a number of internal inquiries, some of them admittedly limited. It is our view that a further inquiry on the basis of the information submitted would be unlikely to be productive. Further, it would have the effect of diverting managers and practitioners from their main task of caring for children.

5.47 We have satisfied ourselves that the Department, through its own sources and the information provided by us, have such information as is relevant to enable them to take all appropriate steps for all persons in respect of whom concern was expressed as to their suitability to have contact with children.

c. What lessons can be learned for the future?

5.48 Investigation into allegations of abuse or bad practice should be thoroughly and professionally investigated and carefully documented at an early date. Reopening investigations such as this years after the event is fraught with difficulties.

Lesson 77: A decision of the Procurator Fiscal not to prosecute does not absolve the Department from the responsibility of considering the appropriateness of undertaking its own investigation.

Lesson 78: Failure to investigate can mean that the allegations remain for many years until they reach the stage at which they are, to all intents and purposes, incapable of resolution.

Lesson 79: Failure to reach a resolution can lead to disquiet, disturbance and the potential for detail to be lost or to be built on.

Lesson 80: When a report, like the 1989 Cruachan investigation report, sets out recommendations for action, dates should be set for implementation and progress monitored.

6. WHAT LESSONS MAY BE LEARNED FROM THE PAST?

A. List of Lessons

6.1 The lessons identified throughout those parts of the report dealing with the past are set out here in the order in which they appear in the report. This means that some are repeated as they were prompted by more than one situation. The purpose of setting them out in this way is for ease of reference when discussions and recommendations later in the report refer back to them.

Lesson 1: It sometimes seemed to the children that other staff must have known what was going on.

Lesson 2: Some children were so young when the abuse started that they did not realise it was wrong.

Lesson 3: The children did not generally discuss the abuse with each other. It was experienced as a private matter. However, there was often a common, unarticulated understanding which manifested in group activity such as name-calling and repeated patterns of behaviour. Adults did not pick up these signs.

Lesson 4: Recruitment practices were poor. Staff were often young, untrained and inexperienced.

Lesson 5: To the outside world, Glenallan had the appearance of a happy and successful establishment.

Lesson 6: The fact that Glenallan was experienced by the children as basically a caring place made the threat of moving somewhere worse, especially an assessment centre, a powerful inhibitor against telling of the abuse.

Lesson 7: Many of the desirable qualities of residential care staff in terms of empathy with children can also be a screen for abuse.

Lesson 8: Because Glenallan was basically a good place to be, children feared making others unhappy if their reports of abuse led to the home being closed down.

Lesson 9: The children feared being split up from siblings. The threat of this stopped them from telling of the abuse.

Lesson 10: Children's most tender feelings were exploited to keep the abuse a secret.

Lesson 11: Glenallan Staff were unable to communicate their concerns effectively to the external managers.

Lesson 12: External managers did not recognise that there were serious problems in Glenallan.

Lesson 13: There is a danger of decisions about placements being inappropriately influenced by the need for independent organisations to maintain an income flow.

Lesson 14: The children in Dean House were not aware of McLennan having a boss.

Lesson 15: At Dean House, the key worker system seems to have existed in name only. McLennan was in effect key worker for all the children. He wrote the reports and attended children's hearings with them. It is dangerous to allow too much power to be concentrated in the hands of one person.

Lesson 16: At Dean House, bath time was the occasion of much of the abuse. Staffing levels meant that workers were alone with children. Gender considerations were not taken into account.

Lesson 17: At Dean House, the children did not experience contact with field social workers as a safeguard.

Lesson 18: Children at Dean House did not experience children's hearings as a safeguard, as McLennan went with them.

Lesson 19: At Dean House an inhibiting factor was that children felt stigmatised by being in care, and did not feel they would be believed about the abuse. Staff later conceded that, at that time, they did not believe such allegations as were made.

Lesson 20: Dean House seemed to be a happy place.

Lesson 21: There was little awareness at the time that adults could indulge in sexually abusive behaviour. This lack of awareness, and difficulties in articulating and raising issues, would have made it all the more difficult for children to talk about abuse.

Lesson 22: Dean House staff and Governors find it difficult to understand how abuse could have taken place, when there were so many volunteers visiting the house. Visits by community policemen were a feature at both Dean House and Glenallan.

Lesson 23: Staff at Dean House experienced the Governors as distant. They said that their attempts to tell about their concerns were not responded to. This raises the question of the appropriateness of the backgrounds of those running independent organisations in relation to the expectations now made of them.

Lesson 24: At Dean House, people designated as second and third in command were really working as care workers with no supervisory responsibility and nominal key worker roles. It seems astonishing that they did not question the fact that they were being de-skilled and not allowed to carry out their functions.

Lesson 25: Within the Social Work Department at that time there was a lot of autonomy at all levels.

Lesson 26: Dean House was said to have run "on good will," for example as regards the involvement of neighbours on the House Committee. Also the Board ran on the basis of trust. There was no clear allocation of roles and responsibilities and no clear accountability.

Lesson 27: The Social Work Department's link officer with Dean House does not remember a written remit and was not quite sure of his role.

Lesson 28: Demands on field workers meant they did not give children in residential care as much time as they needed. Social workers should avoid the temptation to believe that, when a child enters residential care, responsibility is passed to the residential workers. The reality is that the young person needs their social worker more than ever at that point.

Lesson 29: The investigation which ultimately led to the High Court trial was helped by the fact that the police continued contact with the victims and moved at their pace.

Lesson 30: In areas of joint responsibility, when both police and the Social Work Department each have potential responsibilities in respect of an allegation, and a decision is taken not to proceed further, that decision should be taken at a senior level within the police service and the Social Work Department.

Lesson 31: Residential and field work staff should recognise that name calling may sometimes be a child's way of crying for help. Any such incident should be analysed and, where appropriate, followed up by appropriate and sensitive questioning.

Lesson 32: Social work staff should recognise the possibility that young people might express unhappiness and concerns in different ways. Their training should stress the importance of "hearing" children in this way and interpreting and evaluating its significance.

Lesson 33: The significance of absconding is an issue that has been identified in other reports which have acknowledged that it may be a response to abuse or other unhappiness and have recommended that serious attention be given to finding out why children run away. We add our voice to that recommendation.

Lesson 34: Pressure should not be put on residents to withdraw allegations. This instance seems to have proceeded on the basis of not believing G. This has hopefully changed. The Orkney Report made recommendations about responses to children telling about abuse.

Lesson 35: Withdrawn allegations should be kept on record.

Lesson 36: Allegations should not be investigated by people with responsibilities within, or line management for, the unit involved.

Lesson 37: Victims may later disclose abuse to social work in a different context; in G's case, criminal justice.

Lesson 38: G's 1992 report to criminal justice workers is hard to follow because of sloppy record keeping on the part of the social worker, including illegibility and occasional difficulties in identifying the author. Some of this was due to it being written up in haste because of the impending departure of the worker.

Lesson 39: There should be recognition of the possibility that former residents who may have been involved in offending behaviour or who may, as in G's case, be in prison, may be unwilling to involve the police. This should not be taken as an indication that what they are saying is not true.

Lesson 40: There is a need for guidelines on responding to allegations of historical abuse.

Lesson 41: If a decision is made to proceed no further with investigation of an allegation of historical abuse, the reasons and authority for that decision should be recorded.

Lesson 42: There is a danger of assuming that an allegation by a person faced with a criminal charge is a "smokescreen."

Lesson 43: Too much emphasis on client self-determination regarding reporting and investigating allegations is misplaced when the safety of children is at stake.

Lesson 44: Regarding G, it is critical to reinforce the need for allegations to be properly investigated, and to be clear about action to be taken when staff become aware of a complaint of this

nature but are unable to persuade the complainer to go to the police with the allegations. Guidance on responding to allegations of historic abuse should include some latitude to staff to encourage and assist complainers to report the allegations, allowing appropriate time to pass to enhance their chances of doing so, rather than a blanket instruction to report allegations themselves immediately which might have the result that the essential evidential information from the complainer is never forthcoming.

Lesson 45: Where any person makes an allegation at any time that he or she was abused during childhood when the local authority had responsibilities in respect of that child, the allegation should be recorded and discussed with senior colleagues.

Lesson 46: External managers should enquire into unusual patterns in departure of staff.

Lesson 47: Bad management was felt to be the issue at Glenallan, but this was actually an abusive situation.

Lesson 48: There is a need to set aside the prejudice engendered by people regarded as difficult when they are trying to raise concerns about the safety of children. Later on in this report we explore the issue of external supports for children in care. We note the importance of children having someone outside the Unit to whom they feel they can express concerns. Children choose the people they feel able to talk to. Sometimes the people most trusted by the child in that respect will be the child's parents. Even inadequate and/or difficult parents can sometimes be the child's most trusted confidantes. Even difficult people, holding grudges, can be right.

Lesson 49: It is dangerous to rely on a lack of medical evidence as conclusive proof that abuse did not take place.

Lesson 50: Children can be dissuaded from telling by insensitive or inappropriate handling of allegations.

Lesson 51: Dean House – There is a need for guidelines regarding response to allegations of historical abuse.

Lesson 52: There is a need for guidelines regarding response to allegations of historical abuse

Lesson 53: The demands imposed by probation, supervised attendance and community service orders may be too rigorous for 16 to 18 year olds, and even older young people, given that breach can lead to an early custodial sentence.

Lesson 54: Difficulties in transmission of information can follow on from the departure of staff .

Lesson 55: There is a need to cross reference to earlier files held by other divisions within the Social Work Department.

Lesson 56: There is a need for guidelines on responding to allegations of historical abuse.

Lesson 57: It is important that social workers in criminal justice teams are made aware of their responsibilities in the area of child protection. This case also raised issues for us about the unsatisfactory transmission of information. We find it difficult to understand how a probation officer could satisfactorily supervise a case without access to the information which persuaded the court to make a probation order. We also wonder about the suitability of probation for young people such as Child O with such a troubled history. One of the probation workers told us that she did not see herself

as being there to befriend O. Her job was to carry out national standards and ensure that she adhere to probation terms.

Lesson 58: The question arises again about the responsibilities of the department with regard to ensuring the safety of other children if a full disclosure is not made.

Lesson 59: Children may be inhibited from speaking if interviewed in very formal settings.

Lesson 60: Staff accept their inclination was not to believe Child P.

Lesson 61: Cull's situation demonstrates the implications of employment law for child protection.

Lesson 62: There is a need for clarity regarding the responsibilities of Board and Committee members of voluntary organisations.

Lesson 63: Child P's report was made 1982. A lot has been learned since then about the prevalence and dynamics of sexual abuse. In particular, Lord Clyde's 1992 report into the removal of children from Orkney recommended (9): "The recipient of a confidence from a child must above all display sympathy and understanding and not transmit any element of disbelief." Recommendation 26 of the Finlayson/Newman report of 1993 was that "when a child has made an allegation of abuse, a decision be taken to identify a key individual who would have paramount responsibility to provide appropriate support to the individual child." Current child protection guidelines place greater emphasis on the involvement of the police. All of these post-date the 1982 incident, therefore it would be inappropriate for us to criticise the Governors or social work staff on that basis. However, should similar allegations be made in the future, those with responsibility for child care should be required to observe these three requirements.

Lesson 64: Only the officer in charge knew that Cull was to be monitored and, when he left, no staff member knew. When a decision is made to monitor the progress of a member of staff, there should be clarity about who should carry out the monitoring and how progress is to be recorded.

Lesson 65: Regarding the legal involvement in investigation of Child P's report, it is difficult not to come to the conclusion that, no matter how learned they may have been in their own profession, they would have benefited from some advice, guidance and training in relation to staff supervision and support and dealing with some of the personnel issues which frequently crop up in the voluntary sector.

Lesson 66: Child Q - Education staff must be fully aware of the prevalence of sexual abuse and of their own responsibilities in terms of taking the matter forward. This is particularly so when children are living away from home. The presence of learning difficulties can make it more difficult for a child to identify and articulate their concerns (although Child Q seemed quite clear about it). Adults working with young people who have learning difficulties must be particularly vigilant about identifying when a child is trying to express concerns and in helping them to do so.

Lesson 67: The case of Child Q shows the importance of senior officers following up what action had resulted from allocation of a case to a junior officer.

Lesson 68: Reports from young people with learning difficulties must not be undervalued because of the difficulties they present. This is also an issue for courts. There are indications that attempts were made to discount Child Q's evidence because of his difficulties. Children with learning difficulties are particularly vulnerable to abuse and have particular difficulty in articulating it and in being believed. This is a matter which requires attention at national level. Consideration should be given to the potential advantages of joint interviewing by police and social work.

- Lesson 69:** Management problems were the focus of concern with both Knott and McLennan.
- Lesson 70:** There is a need to have proper “whistle-blowing” procedures to ensure that staff are listened to.
- Lesson 71:** Consideration should always be given to the advantages that might be gained by taking account of the views of residents when investigations are being undertaken within residential units.
- Lesson 72:** There is a danger of over-emphasising the needs and rights of employees at the expense of the children.
- Lesson 73:** It can be tempting to give good references as a useful way of relieving oneself of unwanted staff.
- Lesson 74:** The roles and responsibilities of local authority representatives on the Dean House Board of Governors were not clear.
- Lesson 75:** In Dean House children called McLennan a Perv.
- Lesson 76:** Members of staff should not give references for clients which omit any mention of the nature of their relationship, even if that is now in the past.
- Lesson 77:** A decision of the Procurator Fiscal not to prosecute does not absolve the Department from the responsibility of considering the appropriateness of undertaking its own investigation.
- Lesson 78:** Failure to investigate can mean that the allegations remain for many years until they reach the stage at which they are, to all intents and purposes, incapable of resolution.
- Lesson 79:** Failure to reach a resolution can lead to disquiet, disturbance and the potential for detail to be lost or to be built on.
- Lesson 80:** When a report, like the 1989 Cruachan investigation report, sets out recommendations for action, dates should be set for implementation and progress monitored.

7. REMIT 2 – THE PRESENT

A. Text of Remit

7.1 That part of our remit which concerned the safety of children currently looked after by the Council required us:

2. To view current procedures, practice and guidelines in operation in the City of Edinburgh against the background of –

the High Court proceedings;

the Finlayson/Newman Report of 1993 – “Listen – Take Seriously What They Say”;

the Scottish Office Report – Children’s Safeguards Review” (1997),

to determine:

what safeguards are in place;

the adequacy of these;

the uniformity of their application across the City;

what additional safeguards may be necessary.

B. How information was gathered

7.2 Our starting point for this part of our remit was a written submission by the Director of Social Work which set out what the Department viewed as the current safeguards for children looked after by them. This is reproduced as Appendix 3. We were also presented with an impressive file of policy documents. Further written information and statistics were furnished to us in response to our requests.

7.3 All members of staff of the Social Work Department received information about the Inquiry and how to contact us. In addition, information was circulated to relevant staff members of the Social Work Departments of the other local authorities which had formed part of the former Lothian Region. We had considered this advisable given the mobility of labour facilitated by this earlier association.

7.4 We visited all residential child care units operated by the City of Edinburgh, as well as the two facilities now operated by Dean House. Some children looked after by the City of Edinburgh are boarded outwith the City in residential schools and other institutions. Information about the Inquiry was sent to all such establishments, and we selected three at random to visit. Visits to units were generally undertaken by only one member of the Inquiry team although, on occasion, two were present.

7.5 We each conducted a pilot visit to one establishment to allow us to work out a considered approach to this task. We had thought that we might interview residents and staff individually with a schedule of standard questions. However it quickly became clear that this would be neither practical nor helpful. Our practice in undertaking these visits was to speak to staff in a group, to the head of the establishment individually, and to the residents in a group setting. We often shared a meal with them. Our aim was to create an atmosphere in which current

staff and residents would feel able to tell us what it was like for them living or working in residential care today, and what concerns they might have as regards safety.

7.6 Staff and residents were advised that they could contact us for a private, individual interview, and a few did so. With regard to the young residents, our visit was preceded by distribution of a leaflet telling them about the Inquiry. This was helpfully prepared for us by Steven Paterson of Who Cares? Scotland and is reproduced as Appendix 4.

7.7 We also identified particular individuals whom we would wish to interview and invited them to attend at our office in the Council Chambers. Interviews were generally conducted by two members of the Inquiry team, although on occasion only one was present. Appendix ? sets out the numbers interviewed.

7.8 Information about the Inquiry was sent to all foster carers, with copies of the leaflet for those children and young people able to receive it. We visited three sets of foster carers in their homes.

7.9 We also visited an establishment for special needs children operated by a voluntary organisation and interviewed the head of the relevant project.

7.10 Conscious of the public interest in the matters which we were addressing, we held a week of hearings in public from 1 to 5 June, 1998, during which senior members of staff of the Social Work Department and relevant agencies were questioned on the basis of the information which we had either received or heard during the previous period of research.

C. Audit of current procedures, practices and guidelines

7.11 The Director of Social Work's written submission set out what the Department viewed as the current safeguards for children looked after by them. They fell within the following broad headings:

- Council policy – reflected in a number of documents, some of which applied to the Council as a whole with others specific to aspects of child care;
- Departmental practice, guidelines and procedures;
- The identification/reporting/handling of concerns; and
- External Monitoring and support.

7.12 The submission also set out what were seen as impediments to safeguarding such young people.

7.13 The Inquiry Team extracted a checklist of items from the submission. We have considered and compared the Department's view with the experience related by young people and by employees of the Department. The items we have considered are:

Principles and Policies

1. The principles underpinning the Council's approach to children looked after by them.
2. How these principles are translated into policy, and how those policies are communicated to staff and young people.

Residential Care –General

3. Standards in residential care
4. Recruitment of staff
5. Training of staff
6. Staff supervision
7. Staff appraisal
8. The Locum Bureau

Dealing with Difficulties

9. Investigation and Staff Discipline
10. Care and Control Policy
11. Recording and Transmitting Concerns
12. Retrieving Absconders

Keeping Watch

13. Inspection
14. Visits by management
15. Visits by Council Members

Identifying and Expressing Concerns

16. Social Workers and Key Workers
17. The “Whistle-Blowing” Policy
18. Reviews
19. Children’s hearings
20. Exit interviews
21. Support through the education system
22. External links through activities and befrienders
23. Client Services and Complaints
24. Children’s Rights Officer
25. Who Cares? Scotland

Foster Care

26. Standards in foster care

Special Needs

27. Children and young people with special needs

Specific Issues

28. Inappropriate Placements
29. Independent Persons
30. Independent organisations
31. Reports of historical abuse

7.14 The report considers each heading and compares intention with reality. It also refers to the impediments acknowledged by the Department. These are:

- Budgetary restraints – capital and revenue;
- Difficulty in meeting training targets; and
- High staff turnover.

8. PRINCIPLES AND POLICIES

A. Introduction

8.1 This chapter of the report takes a broad look at the principles which form the basis of the Council's child care practice, insofar as they impact upon the safety of children looked after by them. It also comments upon the manner in which these principles are communicated to staff and to looked after children and their families.

B. The principles underpinning the Council's approach to children looked after by them.

8.2 The basic principles underlying the Social Work Department's practice are set out in a 1992 document entitled "Our Work And How We Aim To Do It," in a number of policy reviews of residential child care and a Business Plan for 1997/98.

8.3 These show the Department's commitment in principle to:

- Protection of vulnerable children
- Listening to children
- Keeping children within their own families wherever that is safe and appropriate
- Keeping residential units small and manageable
- Encouraging staff in units to become involved in more outreach work, respite care and aftercare
- Keeping under-12s out of residential care, except in exceptional circumstances
- Identifying a particular unit for those under-12s who needed residential care
- Ensuring that children placed in residential care are there as a result of a positive choice in pursuit of their welfare
- Effective management of resources, including fair decisions about priorities
- Reflecting in the Children's Services Plan a corporate responsibility for children.

8.4 This section of the report looks first of all at the staff response to these general principles. We then select some aspects for particular attention: risk taking, residential care as a positive choice, corporate responsibility, and the interaction of child protection, disciplinary and complaints procedures.

a. Staff Response

8.5 In general we found widespread support from staff for the principles outlined above. Many expressed forcefully their own views that residential units should be smaller, with more opportunities for staff to engage in outreach work, respite and aftercare. There was agreement that the availability of more such community support would prevent the need for some children to be received into care at all. However, despite the general support for these aims and some examples of imaginative work in individual cases, set out in a Progress Report considered by the Social Work Committee in September, 1997, we learned of a number of instances, some of which are described below, where such aims have not been translated into practice. One reason advanced for this was the temptation to go for what, on paper, appeared the safer option; to avoid risk.

8.6 Many gave instances, particularly of younger children, where their firm view was that appropriate foster placements would have better met their child clients' needs had such an option been available.

b. Risk Taking

8.7 Some staff felt that effective implementation of many of these principles required a willingness to take risks that was not evident in practice. A few said this explicitly, but it was implicit in many other comments. For example, it was commonly said that departmental policies were aimed at protecting the department and minimising its exposure to criticism rather than about protecting children or promoting their welfare. This perception is referred to in greater detail in chapter 10 of this report, "Dealing with Difficulties."

8.8 There is an element of risk involved in a decision to support a child in a difficult family situation as an alternative to removal into care. There is risk involved in leaving a difficult child in the community. Whilst there was recognition that Departmental policy promoted healthy risk taking in the interests of children, one worker told us that:

The feeling of being supported to take risks goes only so far.

8.9 If workers are uncomfortable with an element of risk, this will adversely affect implementation of many of the principles listed above. Not only will children be received into a costly resource which will not best meet their needs, or be retained there when the money would be better spent supporting them in the community, but the residential resources will then not be available for those who truly need them. As one worker said:

Systems get bunged up because they are not able to move kids out. Field workers are aware of the impact on them of risk taking, so kids stay in care longer and become institutionalised. It also prevents other kids coming in.

8.10 Risk taking is relevant to safety because pressure on resources leads to lack of choice and the making of inappropriate placements. This issue of inappropriate placements is discussed in Chapter 15. A major theme of the staff response to the Inquiry's investigations was that these inappropriate placements in themselves put children at risk. Risk avoidance in admission and rehabilitation leads to increased risk within the care system.

8.11 Management and individual social workers may feel inhibited from appropriate risk taking, designed to promote children's best interests, by awareness of the possibility of simplistic, headline-grabbing media reaction should risk decisions result in unexpected or tragic consequences. "Safe" decisions to remove children from home might protect the Council and their staff from criticism of failure to act but may not best meet clients' needs. Conversely, removal of children where their safety requires such a decision can also result in ill-informed media criticism. The concept, "Damned if they do and damned if they don't" is well recognised by the social work profession. That additional burden in a complex area of work poses additional pressures on them. Public and parental understanding and confidence can be undermined by sensational reporting, (normally with the benefit of hindsight) or individual particular interests being forcibly articulated. Risk taking requires soundly based assessment based on the best available information at the time before any decision is taken to

adopt a residential placement, and staff awareness that in taking this approach they are operating within approved Council policy.

8.12 The issue this raises is: given that there is agreement that a willingness to work with an element of risk can lead to better decisions about children and a more efficient use of resources, what needs to happen to encourage workers to take this approach?

8.13 We believe that healthy risk taking by social workers may be promoted by the establishment of a General Social Work Council which could regulate professional standards. We are aware that a proposal to establish such a Council is currently the subject of consultation. We comment on it again later in this report in relation to checks on prospective employees. Currently, when a decision taken as a result of a careful risk assessment does not pay off, staff face the prospect of trial by media. A department that supports its staff might be viewed cynically as trying to avoid any liability consequent upon admission of error. An independent, professional body which can consider the appropriateness of the worker's response will be able to give more informed, objective, credible judgement than either the media or the employers.

8.14 The establishment of a General Social Work Council is the responsibility of the Scottish Office. Focusing on the Council's responsibilities, our recommendations, set out below, are aimed at ensuring that the Council as a corporate entity supports a more community based approach to helping children in difficulty, and makes the whole spectrum of its resources available to achieve this end.

c. Residential Care as a Positive Choice

8.15 An emphasis on keeping children in their own families, or in foster families, may seem to imply that residential care is the least favoured option. As recommendation 3 of the Skinner Report indicated, this is not the case. There are some young people who cannot remain within their families. The decision to place a child in care represents a major life change for the child and should not be taken lightly. Residential care should be seen as one of a range of options forming a continuum, not as the last resort. It is important to take account of the views of young people about the kind of care they want.

8.16 In the course of our enquiries some young people expressed to us strongly their preference for residential care as opposed to foster care. They preferred the independence of residential care and disliked the forced intimacy of the foster situation. One of them said:

Foster carers want you to treat them like your mum and dad; but you have your own family.

8.17 Two residents with experience of both foster care and residential care told us that they had a greater feeling of safety in residential care. While in foster care they had felt more vulnerable to unwanted approaches by abusive parents. Their perception was that the residential unit provided a more effective physical barrier against parents intent on "tracking them down."

When you're in foster care, there's just these two skinny, wee foster parents between you and your mum and dad. They can just push past them. But here, there's staff around, and some of them are quite big.

d. Corporate Responsibility

8.18 An underlying principle of the Children (Scotland) Act 1995 is that statutory responsibility for children is not limited to the social work department. The whole local authority, and all of its departments, is charged with this responsibility.

8.19 In the course of the Inquiry's public hearings, both the Depute Leader of the Council and the Chief Executive, expressed their commitment to the concept of corporate responsibility. Some earlier initiatives such as the Youth Strategy and the Children and Families Charter, both of which impacted on child care generally and child safety in particular, had lost some of their impetus in the period following local government reorganisation when there had been a need to focus attention on maintaining front line services in the face of budget difficulties. They were soon, however, to be relaunched.

8.20 The Chief Executive acknowledged that the current Children's Services Plan was possibly over-descriptive and lacking in a strategic, corporate approach. However, it was the start of a process and further refinements would be made. He said the process itself had been important in bringing departments together.

8.21 The departmental interface which has historically been of greatest significance for children and young people has been that between social work and education. There have been many joint initiatives between these departments. Indeed, the Chief Executive indicated that the corporate approach taken to the development of the Children's Services Plan had built on joint social work/education initiatives which had continued through reorganisation.

8.22 In the course of the public hearings, the Education Department representatives indicated that their Department was fully committed to preventative work and to educating children locally. Although budgets to achieve this had been given high priority, there nevertheless remained some difficulties in funding such initiatives.

8.23 In the course of visits to units and foster families we found heartening examples of complex travel arrangements designed to enable "looked after" children to continue to attend schools where they already had established links. In other units we met children for whom no school placement was currently available, where attempts by social work and education staff had failed to identify schools which would accept the children on their roll. Absence of a school placement and consequently education and structure for these children, could impact on the suitability of the placement for the child, place additional pressures on care staff and detract from a child's safety by reducing the availability of external contact.

8.24 There are less obvious ways in which a departmental as opposed to a corporate approach can adversely affect children. One example which came to our attention was that of a young person with special needs who lived in residential care and needed a bus escort to accompany her to school. The escorts are provided by the Education Department, although in the public hearings, their representatives suggested the Social Work Department may now

have taken over this particular item of the transport budget. They are required to put the contract out to tender and, we are told, to accept the bid representing “best value.” This resulted in the loss of the escort with whom this young person had formed a trusting relationship.

8.25 The girl, “H”, told us:

I am very annoyed because my bus driver and escort were moved to another school. They are both my friends. M has always been kind to me and gentle. I was crying on the bus today because I want her to stay with me for good because she’s funny and always made me laugh. I miss all the fun we had. I wish they could leave us alone.

8.26 H had herself telephoned to complain about the change, but said she had received no response to the message she had left on the answering machine. Her residential worker indicated that H had established a very close relationship with both her driver and her escort. On most days, the support and encouragement they provided made the difference between H having a good or bad day in school. Whatever the reasons for the changes, she said, H’s needs and feelings had not been considered.

8.27 Later in this report (in Chapter 16) we discuss the importance of trusted, external links for children in residential care, especially for those with special needs. A more corporate approach would ensure that the interests of children were taken into account as a primary consideration when tenders were being considered.

8.28 Corporate responsibility is relevant to child safety because more options will be available for children if the resources of the Council as a whole are harnessed in implementing its responsibility towards children. A more corporate approach is likely to lead to better use of resources. A true commitment to corporate responsibility, and a proper working out of its implications, will also ensure that the safety of children is not prejudiced by the actions of other departments working to different agendas.

Recommendation 1: The Council as a whole should explicitly acknowledge its corporate responsibility for children looked after by them and its determination to ensure that this is fully reflected in policy formulation and practice.

Recommendation 2: The Council should publicly acknowledge their acceptance that there are risks involved both in keeping children in the community and in looking after them, and should ensure that its professional staff feel supported in implementing decisions arising from risk assessments.

Recommendation 3: The Council, through the Chief Executive, should devise a comprehensive care strategy which recognises residential care as part of a continuum. It should draw on the expertise of all departments of the Council and should include a clear strategy for community based support for children and young people in order to avoid inappropriate use of residential resources. Residential care must be used and available where it is a positive choice for young people.

Recommendation 4: Provision of residential units must be at such a level as to allow a genuine choice of placements to best meet the needs of young people. In implementing this recommendation, the Council must accept that this will require units to operate at times at less than maximum capacity.

Recommendation 5: In pursuit of Recommendation 3, the Council, through the Chief Executive, should set up a high level task force drawn from all of the departments and agencies which would be involved in the preparation of Children's Services Plans with a remit to devise a corporate strategy for more community based support for children and families, drawing on the resources of all relevant departments. The conclusions of the task force should help shape future Children's Services Plans. In particular, the task force should: (a) produce a plan for requiring a child impact analysis to be attached to all policy developments or practice changes proposed by the Council; and (b) ensure that their new initiatives, replacing the former Youth Strategy, incorporate the need to identify immediate school placements for all looked after children.

e. Interaction of child protection, disciplinary and complaints procedures

8.29 The commitment to the protection of children listed above is fleshed out by the Director of Social Work's written submission [3.4.1] which says:

Section 6.2 of the Council's Child Protection Guidance sets out the action that must be taken whenever an allegation is made by a looked after child. Such allegations must be dealt with under child protection procedures. This ensures that the child's safety takes precedence over complaints or disciplinary procedures. Complaints and disciplinary procedures are suspended while child protection procedures are investigated.

8.30 Four of our consultees expressed concern that, whilst the initial reaction to a child protection concern was based upon the interest of the child, this focus became less obvious as the staff disciplinary process of investigating the allegation gained momentum and became more formal. Three of these related to one recent case within the department. The fourth related to an employment issue which had arisen within a voluntary organisation.

8.31 Lesson 72 from the past also referred to a past policy in relation to employees with alcohol problems, which placed the welfare of the employee above considerations of the welfare of children.

8.32 These are particularly sensitive matters involving the rights and interests of residents and staff. They are discussed in greater detail in Chapter 10 in connection with issues about investigation and discipline, but are referred to here because it seems to us that there is an issue of principle involved which tends to get lost within the details of procedures serving different agendas.

C. Communicating principles through policies

8.33 The Finlayson/Newman report had recommended (Rec. 10) that all units ensure that the relevant procedures and other documentation were available within the Unit, and that all grades of staff should be expected to know the contents and incorporate them into practice. During the public hearings, the Director of Social Work indicated that this recommendation was one of those which had been implemented.

8.34 His written submission stated:

Council Policy has developed over a number of years and is not contained in a single document but has to be read in a series of reports, mainly those of the Social Work Committee.

8.35 Formulation of policy is a means to an end. It is an important and necessary starting point, but will have little effect if it is not communicated in a way that demonstrates its relevance and makes sense to people. In the course of our enquiries, we have been presented with vast quantities of paper. We are grateful for the effort the Department has made to collate this information for us. However, it does underline the question about how busy practitioners can be expected to read, understand and internalise all of the information that is relevant to their work.

8.36 This section of the report will look at information issues relating to: residential child care staff, children and parents, social workers, and other Council departments.

a. Residential Child Care Staff

8.37 Residential workers told us about a staff file or “blue folder” containing documents relevant to policy and practice, such as Director’s circulars. There were differing views about how well this system worked. Some managers appeared to take responsibility for sifting what was relevant and communicating it to their workers. Others left the workers to read it themselves, which it seemed some never did. Some were unsure how up-to-date the folder was and thought it probably contained some material which was out of date and did not contain some information that it should. Some unit managers ensured that new circulars or relevant information were formally discussed at team meetings. Others did not. Even where meetings did discuss the documentation, there was no certainty that staff who for any reason missed that meeting would be aware of the content of the material.

8.38 There were also comments on the way the material was presented. For example:

There’s so much guff comes in. It feels like we get absolutely everything about everything; stuff about elderly and the mentally handicapped. Also, the format is not quite committee report but along those lines. You have to read it three or four times and it is very boring. It feels like it is not written from a practice perspective but from a departmental perspective. It’s the Party Line. Practitioners do get invited onto working groups, but maybe they should also participate in the drafting of the policy. It needs to speak the right language.

8.39 Policy needs to be presented in a way that demonstrates its relevance, or it will not engage the attention of workers with other things to do. In the course of our visits to Units, we made a point of asking about the recently circulated “Whistle Blowing Policy”, more formally known as “Free Expressions of Concern.” The Social Work Department regarded this as a highly significant development, which was discussed with unit managers at one of their regular meetings with the Head of Operations. Issues about the policy itself and the reaction to it are discussed later in Chapter 12 of this report. At this point we are concerned with the impact it made upon staff as a consequence of the way in which it was presented.

8.40 One manager commented that it had not made a huge impact because it was seen as related to the trial and workers did not necessarily see the relevance to them. What did engage their attention was information which impacted upon them more directly, such as the review of residential services. Another manager thought the impact would have been greater had it been sent out as a flyer with a telephone number attached, instead of as a committee document.

8.41 The Department's intention was that all permanent and temporary employees should receive a copy of the policy document. However this had not always happened. In some units everyone had received an individual copy. In others, it appeared that the manager had received a copy. Different approaches had been taken by managers to bring it to staff's attention; some being more proactive than others. One unit thought it might have bypassed them because they did not have a manager in post. A few staff claimed not to have seen the document.

8.42 Some staff have suggested that policies and procedures are issued to cover the department's back rather than to protect children. We believe it is important to counter this allegation by ensuring that documents are presented in a way that has a real impact upon staff.

8.43 We were impressed with a video produced by Barnardo's called *Sounding the Alarm* which set out real dilemmas involving raising concerns about colleagues. This kind of resource, presented and discussed in staff teams, and supplemented by a simple flyer giving basic information, is more likely to have an impact than a formal document.

8.44 Where written material is necessary it should be piloted with a group of practitioners whose job it should be to help make it readable and relevant. This may give staff a greater feeling of "ownership" of these policies and encourage them to fulfil their own responsibilities to read and implement them. "Action points" attached to the documents should make it clear what different members of staff, for example, unit managers or residential care workers, are expected to do on receipt.

8.45 We are also of the view that, if a document is important enough to send out to a unit, it is important enough to be discussed.

8.46 Unit managers should adhere to a consistent positive practice in relation to dissemination of information contained in departmental procedure documentation. Each new document which contains material relating to practice and procedure which has the potential to impact on children's needs should be discussed at the first team meeting after its reception within the Unit. One member of staff should be designated (the manager may appoint him or herself to the task) to lead a discussion on the contents of the documents and its particular relevance to the Unit and children resident there. In addition, (and of relevance for staff who may not have attended the team meeting) staff members who hold supervision responsibilities should include in their next supervision session discussion on the document and its implications for practice and satisfy themselves of the supervisee's ability to fulfil the responsibilities as set out and to implement them. The supervision record should include reference that this has been done. All staff should have ready access to the documentation and be encouraged to read and familiarise themselves with the totality of what is written.

8.47 If team and individual discussions conclude that the recipients do not know what is expected of them, this should be fed back to the Directorate.

Recommendation 6: The Director of Social Work should review the policy and practice guidance issued to staff by providing an easily understood manual for residential workers. In particular: (a) practitioners should be involved in advising on the presentation of that manual and such subsequent materials as are produced; (b) action points should be identified on policy and practice material so that there is no doubt about how recipients are expected to respond; and (c) policy and practice information, and in particular new information, should be discussed in team meetings and in the following supervision sessions and backed up by training where appropriate.

b. Children and Parents

8.48 We were also interested in the way in which information was presented to children and parents on admission to residential care. Skinner had recommended (Rec.16) that children and young people being admitted to care should be given a written statement of their rights and responsibilities. This should cover key points related to the eight principles underlying the Skinner recommendations, one of which was about a “feeling of safety.”

8.49 It seemed to us that there was a wide variation of practice and standard of written information about Units. In some cases it was excellent. In one Unit, staff admitted that written information for parents and young people on admission was poor, but said they made up for this through personal communication. Residents did not agree. They told us that they had been told what not to do rather than what to do.

8.50 In many situations, personal communication can be an effective way of presenting information to children and parents. However, it needs to be backed up by relevant and appropriate written information.

Recommendation 7: The Director of Social Work should review the written information residential units give to children and parents on admission, with a view to ensuring a consistent high standard. The section on safety should include information for young people about what to do if they feel unsafe. The department should set a timescale for this task and ensure that resources are available to produce good quality booklets that young people will look at and keep for reference. Key workers and field workers should ensure that young people looked after by the Council have received and understood the booklet’s contents.

c. Social Workers

8.51 Lessons 37 and 57 above, drew upon the experience of former residents in reporting their abuse to social workers in the criminal justice team. We were anxious to discover whether social workers in areas other than “children and families” were aware today of their responsibilities with regard to child protection.

8.52 When asked about this during the public hearings, the Director of Social Work confirmed that all members of staff, including those in criminal justice teams and community care teams, were aware of their responsibilities with regard to child protection. They each had a copy of the 1994 Child Protection Guidelines, and would receive a copy of the updated version, which he expected would also address allegations by young adults about historical abuse.

8.53 We believe it is imperative that social workers outwith children and families teams are given readable and relevant information about how concerns about child protection and child welfare impact on their own responsibilities. This includes those working in care in the community and mental health as well as criminal justice. Therefore:

Recommendation 8: The Director of Social Work should ensure that all social workers, not just those in children and families' teams, are given readable and relevant information about how child welfare and child protection concerns impact on their own responsibilities.

d. Other Departments

8.54 This concern also extends to other departments in pursuit of their corporate responsibility towards children; for example, education, housing and recreation. However, having identified above that some residential workers feel swamped by information of dubious relevance, we would be concerned if our recommendations led to a similar fate for other workers.

Recommendation 9: The Chief Executive should ensure that workers in all Council departments are given a simple, strong, persistent message which inculcates in them the habit of taking account of the welfare of children. Information should be provided about the Council's policy and contact points for staff if they want more information or have concerns.

8.55 There will be some workers in other departments whose work is particularly likely to impact upon child welfare and protection. The Education Department is clearly one of these. We are aware that this department does have child protection guidelines and has provided some training for staff. However, there may be staff in other departments such as housing and recreation whose role is also pivotal from the point of view of the safety of children and young people. It may not be clear to these departments or their employees just how crucial their role is in this regard. The Director of Social Work and his staff may be of assistance in helping Heads of Departments to identify the crucial roles. Therefore:

Recommendation 10: Heads of Departments should consult with the Director of Social Work to identify employees whose work is likely to have a particular impact upon children with a view to offering them more detailed guidance on ensuring that the interests of children are given a high priority.

D. Principles and Policies - Main Themes

8.56 Specific recommendations have been made within the chapter, but the main themes which emerge from our survey of principles and policies are:

- the need to develop an effective corporate strategy for keeping children in the community as an alternative to removing them from home;
- the need for an even-handed risk assessment before a child is taken into care, so that children are not removed from home because it seems on paper to be the safer option; and
- the need to involve representatives of the planned recipients of information when it is being prepared to help make it relevant and readable.

9. RESIDENTIAL CARE - GENERAL

A. Introduction

9.1 This chapter of the report considers the general standards, particularly material standards, which are expected to apply in residential care, insofar as these impact on the safety of looked after children. It also considers how permanent and temporary staff are recruited, trained, supervised and appraised.

B. Standards in Residential Care

a. How standards impact on safety

9.2 Material standards in residential care are important, not just for reasons of physical comfort, but because the safety of children requires that standards be consistently high in all units.

9.3 It is important that standards are high because, if a young person is in residential care, it should be because they really need to be there. The feeling of belonging and the desire to remain in the unit must be strong enough to overcome the external pressures encouraging young people to run away or to return to unsafe situations.

9.4 It is important that standards are *consistently* high because the knowledge that there are worse places to go to can inhibit children from telling about abuse. This is one of the lessons to be learned from the past (Lesson 6). It was a consideration in the cases of some of the victims from Glenallan and Dean House, both of which had the reputation of being amongst the better facilities. Transfer to a "less good" unit was feared by the residents and sometimes used as a threat by the staff.

b. Setting out standards

9.5 The Director of Social Work's written submission referred to the standards currently adhered to by the Department:

Quality in Caring – Standards for Residential Child Care were approved by Lothian Social Work Committee in September 1992 as the basis for inspecting residential child care facilities in all sectors. The standards also underpin staff training and service management.

c. Inspection

9.6 The Council had introduced inspection of its own residential units before regulations required this. Inspection is carried out by Edinburgh and Lothians Registration and Inspection Service (ELRIS), whose functions are discussed in greater detail in Chapter 11. ELRIS has a remit for all four authorities which succeeded the former Lothian Region. This facilitates consistency across Lothian. Where children are placed outwith areas covered by ELRIS, the Units involved are subject to their own standards and inspection.

9.7 ELRIS is responsible for inspection and registration of local authority and independent units. An additional measure of control over independent units is achieved through the

conclusion of Agency and Service Level Agreements between the Council and the independent agency.

d. Variation in standards

9.8 It became clear to us that there was considerable variation in standards amongst residential units; both in the material quality of the units and indeed the ethos. To an extent, variety is a positive thing where it opens up choice and enables a matching of a young person with a particular resource. We are not saying that all units should be the same. However, the units we saw varied across the spectrum of acceptability insofar as provision of a quality home for children was concerned. Some of them were frankly unacceptable in terms of material standards or ethos and could not be regarded as providing a setting conducive to stability and safety.

9.9 Material standards and ethos were often related. Staff in some Units complained about the lack of choice in furnishings due to bulk purchasing arrangements. One Unit had managed to overcome this and had involved residents in making a choice from a wider selection. The whole tone of the place was more homely. The view was expressed to us that a comfortable unit where the residents had some choice about the furnishings (of communal as well as personal areas) was less likely to be subject to vandalism and more likely to contribute towards a calming atmosphere.

9.10 This confirmed the insights of the Skinner Report which had recommended:

Rec. 63 - Officers in charge of residential children's homes should have delegated authority for budgets concerned with day-to-day running of the home including food, general supplies, decoration and minor repairs.

9.11 Skinner had also recommended (Rec. 24) that young people and children should always have access to simple food such as fruit, tea, juice, biscuits, bread, milk and cereal. The Report commented (paragraph 3.3.12):

The kitchen should not be locked. If there is a large store, it may have to be locked. Locking all food away, as some homes do, conveys a real sense of deprivation and does not feel at all like home.

9.12 In one of the Units we visited, the young people told us that the food cupboard was kept locked and they did not have access to snacks without asking staff for permission, which was often refused. They identified this as a considerable source of frustration contributing to the unsettled atmosphere in the Unit. One young person commented:

This is supposed to be our home, but everything's locked away.

9.13 Staff disagreed with this representation of the situation. They said that some food was locked away because residents had been indulging in "food fights," but that some food was always available to them.

9.14 We were also concerned that the layout of some units would make it difficult to keep track of where people were and could create the kind of physical environment in which abusive behaviour, by staff or other residents, was less likely to be detected.

9.15 Our perception that there was a variation for standards across the units was supported during the public hearings by the Head of ELRIS. He said inspectors had made recommendations for improvement. Devolved management of resources to units or unit clusters would allow greater flexibility for minor repairs, furniture upgrades, etc.

9.16 The Convener of the Social Work Committee expressed to us his own view that the physical standards of some buildings were “lamentable” despite recent improvements. He was hopeful that the forthcoming Corporate Capital Budget Review would listen sympathetically to social work requirements.

9.17 Our conclusion was that there was a significant degree of variation in physical standards and that some of the current standards in terms of the physical environment were not being met.

e. Spot Purchase Arrangements

9.18 We noted above that the Council could exercise a measure of control over standards in some independent units through Agency and Service Level Agreements. These would be the result of negotiation about standards and costs. However, some places for young people are bought “off the shelf” through “spot purchase” arrangements. Some of these would be located in areas subject to ELRIS inspection. Others were not, although they would be inspected locally.

9.19 We have two concerns about “spot purchase.” Firstly, whilst it should be possible to place reliance on local inspection processes, the Department would not have the more intimate knowledge of the institution which can be gained when one is the inspecting authority. Secondly, there is a concern about the possible temptation to hang onto children inappropriately when they are seen as a source of income. We commented on this in relation to past events at Dean House (Lesson 13). Agreements which provide for the purchase of a number of beds, whether occupied or not (which Dean House now has with the Council), provide greater security for these establishments and lessen a possible temptation to accept children inappropriately and to hold onto them for longer than their interests demand.

9.20 On the other hand, we must also acknowledge the temptations placed in the way of the Department to fill places pre-paid through bulk purchase arrangements, whether or not they are the most suitable to a child’s needs.

9.21 During the public hearings, we were assured that there was very little spot purchasing of services for children. However, it does happen.

9.22 It would be impracticable to suggest that there should be no spot purchase arrangements as this might block access to very specialist resources for particular children, however we believe that extra care must be taken to ensure that children’s interests are not prejudiced.

Recommendation 11: Where a spot purchase arrangement is entered into for residential child care, the Director of Social Work should ensure that extra vigilance is applied to identify and act upon any concerns about standards of care for the child. Appointed Visitors (see Recommendation 125 below) would be an important additional safeguard, as would visits from the Children's Rights Officer and the Who Cares? worker.

C. Recruitment of Staff

9.23 Lesson 4 above was that recruitment practices at the time of the abuse were poor. Young, untrained and often inexperienced staff were allowed to care for the most vulnerable children.

9.24 Many reports, but particularly the Warner Report, have made reference to the crucial importance of appropriate recruitment in securing a safe environment for children. The concern with recruitment was evident in the comments made to us by the victims of past abuse and was echoed by current staff. It is clear that practices in the past were very lax. There was a lot of talk about people being recruited in pubs and going on shift with no training or checks being conducted. Indeed we came across an example of a "pub recruitment" as late as 1993. It is clear that much has been done to put more appropriate procedures in place.

9.25 The Finlayson/Newman report had suggested (Rec.2) that the Department consider the need to develop methods of recruitment which ensured consistency and thoroughness in selection procedures, possibly through a combination of central and district staff. At the very least centralised personnel section and managers should oversee closely the recruitment policy and process to endeavour to ensure these standards. The Director of Social Work indicated during the public hearings that this recommendation had largely been implemented. Ongoing developments would complete the process.

9.26 The Kent Report had also made strong recommendation regarding recruitment, with a special plea that implementation of the Warner recommendations be made mandatory (Rec. 14).

9.27 In addition, Skinner, Finlayson/Newman and Kent had all made recommendations about the benefits of probationary periods and induction for new staff.

9.28 The Director of Social Work's written submission [2.2.3] says:

In September 1994, Lothian Regional Council approved a policy for the Recruitment and Selection of Residential Care Staff. Whilst the main elements of the policy have been implemented and carried over into the City of Edinburgh Council, there are a number of aspects which were never fully implemented, partly as a result of other changes running up to the preparation for Local Government Re-organisation, but also because of some resistance from the Trade Unions. The specific elements not implemented are:

- A probationary period for new appointees;
- The advertising of unit manager posts nationally;
- Content of areas covered in interview.

9.29 The submission indicated that work was underway to take forward outstanding matters. In particular there was a proposal to establish a Recruitment and Development Centre for Residential Child Care which would act as a single entry point for those wishing to work in residential care, either on a permanent basis or as Locums. A three day assessment would involve psychometric tests, references and police checks (which accorded with current practice). Personality questionnaires and standardised interview questions would be introduced. After approval, workers would act as Locums or temporary staff for a period of 12 months during which they would be subject to supervision and assessment by qualified practitioners. If considered satisfactory, the member of staff would be recommended to the Appointments Board for permanent employment. This proposal has since been approved by the Council.

9.30 In the course of our enquiries, we sought views on the current recruitment procedures and on the idea of a Recruitment and Development Centre. Specific issues were raised by staff about the implications of the Council's equal opportunities policy, and also about the use of Locums. There was a general acknowledgement that recruitment procedures had improved vastly in recent years. The Recruitment and Development Centre was seen as a good idea.

9.31 Some residential workers were concerned that singling out residential workers for special recruitment and other procedures would be a disincentive and that the Centre should be used for field workers as well. However, the Kent Report (para. 8.4, page 108) had observed that "the care of children is so special and so important that recruitment procedures should be different." The BASW Scottish Committee expressed their view that residential workers needed to be checked with the same amount of thoroughness as foster carers. This kind of approach was also suggested by some of the victims of past abuse who felt it would be appropriate for prospective staff to be visited in their own homes. Some thought their relatives should also be interviewed in order to gain a fuller picture of the candidate.

9.32 Our own view is that work in residential care involves a particular charge of trust. It is appropriate that high standards be required. It would make more sense if the requirement for higher standards were seen as a reflection of the importance of the job, which was then reflected in employment status and salaries. Otherwise it could be experienced as a disincentive.

9.33 We were very impressed with the proposals for introduction of the Recruitment and Development Centre for Residential Child Care, as a reflection of the Department's commitment to the safety of children and willingness to change, develop and learn from past experience and recent studies.

9.34 It came to our attention that some of the independent agencies caring for children looked after by the City of Edinburgh were relatively small. Whilst we have no adverse comment to make on their own recruitment processes, we believe that there would be benefit to all if they could have access to the expertise of the Centre.

Recommendation 12: The Director of Social Work should consider making the facilities of the Recruitment and Development Centre for Residential Child Care available to those independent agencies caring for children looked after by the City of Edinburgh.

D. Equal Opportunities

a. Recruitment

9.35 Many of the people we spoke to raised the issue of the impact of equal opportunities policies on recruitment procedures. Some described it as too standardised and overly-restrictive: “politically correct” in a derogatory sense. It could make it difficult to pursue an issue that might be particular to one candidate. Others who had been involved in interviewing prospective staff commented that they themselves generally found ways of overcoming what they saw as difficulties presented by the equal opportunities format and managed to “work in a hunch” where appropriate.

9.36 The potential effect on children of a rigid application of equal opportunities policies was explored by the Warner Report (paragraph 4.65) which commented that:

It is no part of an effective equal opportunities policy to introduce such rigidities into the selection process that employers place themselves in a position whereby they are prevented from obtaining all relevant information about a candidate before making an appointment.

9.37 It would be wrong if the ability to ask the right questions were dependent upon the skill of particular managers in “working in a hunch” and possibly subverting the approved procedure. If the procedure is inappropriate, it should be changed. We hope that the establishment of the Recruitment and Development Centre will allow for a more professional and consistent approach to questioning of candidates and help identify any procedures which are acting against the interests of children by barring access to relevant information.

b. Sexuality

9.38 The Finlayson/Newman Report had recommended (Rec. 3) that the Department should continue and extend the practice of including a number of issues, including sexuality, in interviews.

9.39 However, the procedures adopted in 1994 held back from a full endorsement of the Warner recommendation with regard to exploring with candidates their sexual orientation.

9.40 Our concern is not whether candidates are heterosexual or homosexual, but whether they are sexually oriented towards children. A candidate with paedophile tendencies might not recognise that at the point of applying for the post.

9.41 In the course of the public hearings, the department’s Personnel and Training Officers expressed the view that the more comprehensive selection process being developed through the Centre referred to above would allow greater opportunity to explore these issues. This would help identify those individuals with paedophile tendencies who might not even have recognised it themselves. It also has to be acknowledged that there may be some who seek entry to child care in the full knowledge that they are sexually attracted to children and

that some might be skilful in manipulating the tests performed upon them. Testing is helpful, but cannot be relied upon to identify all potential offenders.

9.42 We are aware that current procedures for the recruitment of Locums (discussed in greater detail below) do involve completion of an extended questionnaire which might help identify those with paedophile inclinations. This will provide a good starting point for the new Recruitment and Development Centre.

Recommendation 13: The Director of Social Work should ensure that the procedures set up by the new Recruitment and Development Centre for Residential Child Care continue to reflect the spirit of the Warner recommendations on attitudes to sexuality, with a particular focus on the identification of inclinations towards paedophilia.

9.43 Lesson 7 was to the effect that many of the desirable qualities of residential care staff in terms of empathy with children can also be a screen for abuse. We acknowledge that the Recruitment and Development Centre undertakes a rigorous scrutiny and that there is a limit to the effectiveness of recruitment procedures in identifying potential paedophiles. There will always be a need for careful supervision and processes to help identify and progress concerns about employees.

c. Gender Issues

9.44 There was a specific concern about the inability to advertise posts or select candidates on the basis of gender. Some staff teams lack an appropriate gender balance. This can be a problem particularly where night staff are concerned. One unit manager identified as his greatest concern the fact that he had “an unsophisticated male night staff who were inadequately managed.”

9.45 In the course of the public hearings it was explained that the Council’s Personnel Department had, some 18 months ago, reiterated its advice that it would be against equal opportunities legislation to advertise or recruit on a gender basis. Gender was not seen as a genuine occupational qualification. Some interviewees expressed the opinion that the Council should seek exemption from the equal opportunities provisions to allow them to achieve an appropriate gender balance on the staff of residential units.

9.46 The Social Work Department’s Personnel Services Manager expressed the view that establishment of the Recruitment and Development Centre would alleviate the problem as there would be a pool of recruits who could be matched closely to the needs of particular units, with gender being one of the relevant factors. However, it did bother him that this restriction was still there and could present some difficulties.

9.47 It concerns us greatly that the achievement of a gender balance in residential child care is not seen to be a legitimate exception to the equal opportunities provisions. We are not in a position to question the advice received, but we think the question is important enough to be pursued.

Recommendation 14: The Council, through the Chief Executive, should continue endeavours designed to obtain exemption from equal opportunities requirements to allow an appropriate gender balance on the staff of residential child care facilities. If this is held not to be possible within the terms of current law or policy, the matter should be raised at national level.

d. Involvement of Young People

9.48 The Kent Report (paragraph 6.1.5) commented on the involvement of young people in the recruitment process:

Young people from the children's unit in question should if possible be involved in the recruitment process, after due preparation. It should be made clear to the candidates and to them that they have no right of decision-making, but that their views will be taken into account. They may be sensitive to undercurrents that adults will ignore, and may be able to alert the interviewers to something which should be investigated at another stage in the vetting process. At the very least, they are likely to see whether a candidate is capable of communicating with young people.

9.49 The principle of involving young people seems to have gone in and out of favour, creating some confusion. One unit manager said that, when she had started in the post, she had invited candidates for jobs to lunch with the young people. She was told to stop because it was against equal opportunities. However, the Kent report had brought this practice back into favour. Staff now did not know what to do.

9.50 During the public hearings, the Personnel Services Manager explained that the Department's current recruitment procedure did allow for unit visits by applicants, together with meetings with staff and young people. However, he understood the option was rarely used, partly because of the need to offer, and arrange, it for every applicant.

9.51 The Scottish Committee of BASW (The British Association of Social Workers) indicated to us their belief that there was a very real case for young people to be part of the recruitment process. Whereas equal opportunities legislation may present problems, these should be surmountable. Young people should however not be directly involved in recruitment to units in which they themselves were resident.

9.52 In our view, young people, properly briefed about their role, do have a contribution to make to the selection of staff. The setting up of the Recruitment and Development Centre for Residential Child Care gives every opportunity for young people to play a positive role in recruitment. It gets around any perceived difficulty of young people potentially interviewing their "own staff" as applicants will be applying for employment generally, rather than for a post at a particular unit.

9.53 The recruitment procedure proposed by the new Centre indicates that candidates:

Will be required to visit a young persons' unit. These visits will last about two hours, and will offer candidates the opportunity to meet members of staff and young people. During the three day selection period, candidates will be asked to prepare a short piece of written work based on their unit visit.

9.54 This is a good start. It does not specifically address the issue of feedback from the young people. We suggest that the department consider how feedback could be obtained and

taken into account when a decision was made about the suitability of the candidate. However, the final decision would rest with the Department.

Recommendation 15: The Director of Social Work should consider how to incorporate and develop the use of feedback from young people with experience of care in the selection processes set up by the Recruitment and Development Centre for Residential Child Care.

E. Scottish Criminal Record Office (SCRO) Checks

a. The Director of Social Work's written submission

9.55 This indicated:

Checks through the Scottish Criminal Records Office [SCRO] are obtained in accordance with Scottish Office Guidelines prior to an offer of appointment being made.

9.56 In 1989 new procedures were introduced to allow local authorities to check with SCRO whether successful candidates for positions involving substantial access to children had criminal convictions or were the subject of pending cases. In 1996, local arrangements were made to allow voluntary organisations which received funding from the City of Edinburgh Council to access similar information from Lothian and Borders Police. These checks are now a standard part of the recruitment process.

b. Recognition of Need

9.57 The need for these checks to be provided is widely recognised. The prominence given to that requirement may tend to give those who have not considered the subject in any depth, an impression that a negative response is a stamp of approval. A senior manager indicated to us that he would see a nil record as being a positive factor in an applicant's favour. Such a conclusion would be unjustified and could promote a false sense of security.

c. Limitation of Value

9.58 Information from SCRO is available only after the point at which the Procurator Fiscal has decided to institute proceedings. A check would not disclose a report to the Procurator Fiscal in respect of which he was yet to reach a decision; nor a report which had resulted in the case being marked "no proceedings;" nor a case which had resulted in an acquittal. The latter two are of concern because the failure of a prosecution or the decision not to proceed with one may have been based on the lack of evidence sufficient to establish guilt "beyond reasonable doubt." The Fiscal may well consider that there remained concerns which might, if tested, satisfy the lower standard of the "balance of probabilities" which would apply in civil cases, children's hearing proceedings and disciplinary matters relating to employment. As indicated in Chapter 2, criminal law is based on the need to protect innocent suspects rather than the protection of children.

9.59 The procedures established in 1989 also made provision for SCRO to report relevant convictions to the local authority as employer where it was known that the convicted person had substantial access to children. Two weaknesses of this procedure are acknowledged: firstly, the detailed nature of a person's employment might not become

apparent in the course of prosecution; and secondly, it is not always possible to identify risk on the basis of the offence of which the person was found guilty. An offence involving indecency might, for example, be tried as a breach of the peace.

d. Examples of Limitations

9.60 The practical implications of these concerns might best be demonstrated with reference to examples encountered by the Inquiry.

9.61 **Example One** involves a case where a residential worker had been suspended for five months for an alleged offence which, had it led to a conviction in the trial which followed, would probably have led to his dismissal. The staff member was acquitted after a trial in the criminal courts. Spelled out, that means the Crown had failed to prove the case on the high standard of proof beyond reasonable doubt. Two subsequent SCRO checks on this staff member produced returns from the police “Not on Record.”

9.62 Such a statement is inaccurate and misleading. No doubt it conforms with the 1989 regulations in that the acquittal did not permit the police to provide information which they had in their possession relating to the alleged offence.

9.63 In setting this out, we do not seek to imply that the staff member concerned had committed the offence. The nature of the response indicates however that allegations could be made against an individual on a number of occasions by different complainers and that, unless the individual was ultimately convicted, prospective employers, including other local authorities, could all be told that he was “not on record.”

9.64 Police departments do have a record of such allegations, including those cases reported to Procurators Fiscal who had decided, whether through lack of corroborative evidence or any other reason, to take no proceedings. In other instances, they may hold information, classed by them as “intelligence” which may well have a bearing on persons’ suitability or unsuitability for work with vulnerable people such as children.

9.65 This was the situation in **Example Two**. A report had been submitted to the Procurator Fiscal alleging criminal behaviour of a sexual nature by a person whose employment brought him into contact with children and young vulnerable people. The Fiscal concluded that the evidence was not such as to enable him to be satisfied that he could prove that a criminal offence had been committed. However, he was so concerned as to the nature of the information put before him, as tending to demonstrate the unsuitability of that individual to work with young people, that he specifically instructed the police to draw his concern to the attention of the Inquiry team. We have notified the relevant Council officials of this. They are considering what action, if any, they must or can take in the light of this information.

e. Disclosure of non-conviction information: “Police Intelligence”

9.66 Some of these defects will be remedied with the implementation of the Police Act 1997. This allows for the disclosure, at the request of specified persons, of non-conviction information from local police records where this is relevant to a person whose work involves

regular, unsupervised access to children. The Act provides for a Code of Practice to be formulated concerning the use of information provided under the terms of the legislation.

9.67 The question which remains is whether the criminal justice authorities may, on their own initiative, disclose non-conviction information to the employers of persons whose work involves substantial access to children. In the course of the public hearings, a senior CID officer confirmed that he did inform the Head of Operations in the Social Work Department of concerns stemming from “police intelligence.” However, such communication was dependent upon the Crime Managers passing the information to him, which might not always be the case. It was then for him to make a value judgement on the importance of any information he received. He recognised there was a civil liberties issue involved, but also noted that national guidance referred to the “greater public interest.” This shows that the police recognise these dilemmas and their responsibilities.

9.68 We have difficulty in fully understanding the nature and status of the information which is provided. It would seem that much of it is communicated orally rather than committed to writing. Whilst we would not want to discourage informal sharing of information, the mode of transmission is important. If what is transmitted is a hunch by telephone, one must ask what the recipient is expected to do with that information. Will he or she have access to the police intelligence on which it was based to support any action to protect children?

9.69 We recognise the commitment by the police to assist; the problems that would be posed in requiring them to provide written information; and the current restrictions on them as a result of the national guidance, which will soon be updated. We do however observe that much is left to the discretion of individuals such as the nominated senior detective (who himself is dependent on information being passed by Crime Managers) and the Head of Operations in the Social Work Department. In the specific examples we have cited, the Procurator Fiscal arranged for the matter to be brought to our notice. We pose the question as to whether the existence of the Inquiry Team provided an impetus and avenue for action which might have been missed if the allegations had been made at another time.

9.70 We are also concerned about how information is passed on relating to those working in departments other than Social Work who have substantial access to children; for example in the education department or in leisure and recreation who do not have the benefit of an established relationship with appropriate police officers. There is a need to clarify these processes. There should be a consistent procedure across all Council departments. We consider that the Child Protection Register holder would be an appropriate recipient of police intelligence in relation to all Council departments, as he is the Council official with dedicated responsibility for the safety of children.

Recommendation 16: The Chief Executive should set up a procedure whereby, apart from responses to requests from departments for SCRO checks, “police intelligence” about Council employees or volunteers with substantial access to children should be directed towards the Child Protection Register holder, whatever Council department is involved.

Recommendation 17: The Council, through the Chief Executive, should consult with the police and SCRO to clarify the expectations of all parties in giving or receiving such information. Council staff should recognise that a “not on record” response from SCRO is not a positive indication of suitability.

f. Change of Name

9.71 In both of the examples cited above, the workers concerned had at some point changed their names. Procedures will have to take account of this possibility. Whilst we understand that birth certificates may already require to be produced, we would add that they should be actively checked to identify any name change.

Recommendation 18: The Council, through the Chief Executive, should ensure that successful applicants should be required to disclose any former names and to produce their birth certificates before checks are carried out.

g. Time Lags

9.72 The main concern of practitioners was the length of time it could take to complete an SCRO check. Examples were provided of one local authority unit where it had taken four months to check a person who had lived abroad, and an independent unit which had to wait six weeks for a reply in relation to someone who had not lived abroad.

9.73 According to the police representative at the public hearings, checks took on average seven days to complete. The Personnel Services Manager estimated the time as “a week or two”. However, both acknowledged that delays occurred when the individuals being checked had lived outwith Scotland as the national UK database was incomplete. Checks could sometimes take several months to complete. The intervening period presented problems for prospective employee and employer. The employee might find another job. The employer was working one person short. The Locum Bureau (discussed below) did not see it as their role to provide cover for a time lag in recruiting permanent staff. Their focus was on short term, emergency cover. Staff indicated that it would help if they could be given some guidance on the time it might take to complete the check.

9.74 It seems anomalous that car registration numbers can be checked instantaneously, whilst persons who might pose a danger to children cannot. Therefore there is a broader issue about the time required to complete checks.

Recommendation 19: The Chief Executive should, through the Chief Constable, initiate an approach to SCRO to seek agreement (a) that checks for prospective residential care workers should be given priority; and (b) if the request cannot be responded to within one week, that an interim response should be made to explain that there will be a delay, together with an indication of the likely timescale.

h. Overnight/Holiday Stays by Young People

9.75 This was an issue raised with us by some of the young people we spoke to. They complained about a requirement for SCRO checks to be carried out on the families of their friends before they were allowed to stay overnight with them. At the emotional level, they found this to be an embarrassment. At the practical level, they said it often took so long that it

put a stop to the idea. For some young people, the existence of concerns about the family hosting the overnight stay could be particularly prohibitive. As one explained:

I come from, and everyone's got a f..... criminal record!

9.76 The Council's "Looked After Children Document 30" indicates that young people might be allowed to stay overnight with friends on a casual basis after informal inquiries; although any unease on the part of staff should result in a formal check being made. If a particular home is intended to be visited regularly by the young person then, it says, checks should be made.

9.77 With regard to the speed with which such checks could be undertaken, during the public hearings, the Planning, Purchasing and Commissioning Manager (Children and Families) indicated that SCRO checks on friends, which would be required only in exceptional cases, were the subject of a special arrangement with the police to get them done quickly.

9.78 This seemed to be at odds with the experience of many of the young people who spoke to us. They indicated that, in their experience, SCRO checks were always required and that they took an unacceptable time to complete. Basically, the moment had passed.

9.79 It may be that the discretion not to carry out checks is not used by staff for the risk-avoidance reasons discussed in Chapter 8. However, we are not in a position to reach this conclusion.

9.80 Later in the report we refer to this issue in relation to absconding where one young person told us that he had stayed away overnight without permission rather than seek an SCRO check on his friend's family. If the system of seeking checks for young people's overnight stays is experienced as over-restrictive, they may well be tempted to put themselves at risk in order to avoid them.

Recommendation 20: The Director of Social Work should ask the Children's Rights Officer to check with a sample of young people their experience of SCRO checks on friends in connection with overnight stays in order to ascertain whether the situation described by some young people to the Inquiry is general or particular to specific Units, and whether the issue continues to be a real concern for young people.

Recommendation 21: The Director of Social Work should ensure that SCRO checks on the friends of young people are not carried out routinely in order to protect the department or individual members of staff. There should be encouragement and support for workers to exercise the discretion and to use the fast track procedure described at the public hearings.

F. Other Checks

9.81 The Director's submission indicated that current procedures involved checking with Social Work Personnel Services which hold information received from English and Welsh authorities about "unsuitable candidates." There is no equivalent in Scotland.

9.82 There has been considerable support in Scotland for the establishment of a General Social Work Council which would provide an additional safeguard through its monitoring of

professional standards. This was reflected in the Kent Report and in some of the contributions to this Inquiry. We understand that the Scottish Office plans to consult on this proposal.

9.83 This development would allow checks to be made on professional social workers in the same way as other professionals. The significance for residential care would depend upon the extent to which residential child care staff fell within the ambit of the Council and its registers. It is our view that residential care workers should be included within the ambit of the General Social Work Council, especially given our recommendations about increasing the level of qualifications.

9.84 However, there remains an issue about those not eligible for inclusion on a professional register and therefore not subject to the same controls. As well as those working in residential child care who might ultimately fall outwith the criteria for registration with the General Social Work Council, there may be workers or employees in other departments, or involved in external activities open to looked after young people, whose suitability to do so requires some regulation.

9.85 The Kent Report recommended (Rec. 13) that a new Consultancy Index be created for those with access to children as a supplement to professional registration provisions. This would “hold the names not only of those convicted, but also of those who have been dismissed, or who have left and would not be re-employed.” Kent suggests it should also cover those who had been transferred to desk jobs to take them away from children. It would be the employer’s responsibility to inform the index, and to tell the employee that this had been done.

9.86 We believe there is merit in the Kent recommendation regarding the creation of a Consultancy Index, although its significance and scope will have to be assessed in the light of the proposals for the General Social Work Council. We do not make a specific recommendation as the establishment of such an index is outwith the remit of the City Council to whom our report is addressed.

G. References

9.87 The earlier parts of this report touched on the matter of references. There are issues both about the provision and receipt of references. Lesson 73 is particularly relevant.

9.88 Currently, applicants must list all previous employment and name two referees, one of whom should be their current or most recent employer. They do not require to record significant gaps in their employment history. Kent suggested that at least one referee should be interviewed, by telephone if necessary. BASW Scottish Committee expressed to us their view that there should be routine interviewing of referees. We endorse this view. It is not enough to interview the current employer. There is a strange irony in the reliance placed on references from current employers. If the employee is satisfactory, the employer may not want him or her to be successful in obtaining a new position. If the employee is unsatisfactory, there may be a temptation to hasten his or her departure by helping the employee towards another position. Current employers must be regarded as persons with an interest in the outcome of the proceedings.

9.89 This may have been an issue with regard to the past events referred to earlier in this report relating to Brain McLennan, who was able to move from the post of Depute Officer in Charge at Clerwood to Officer in Charge at Dean House, and then from Dean House to an institution in England, on the basis of satisfactory references, despite the concerns which had been expressed about him. The last of these references was written on local authority notepaper.

9.90 It is important that the Council takes this matter into account, both when seeking to employ, and when asked for a reference for one of its own employees.

9.91 We also expressed our concern (Lesson 76) in relation to past events about a circumstance in which a member of staff gave a reference for a former client with no mention of the status of their former relationship.

Recommendation 22: The Director of Social Work should ensure that the recruitment processes for the Recruitment and Development Centre for Residential Child Care should (a) involve seeking explanations for significant time gaps in employment history; (b) routinely involve interviewing both referees; (c) indicate that the Centre retains discretion to approach previous employers who have not been named as referees, and make it clear to applicants that this is a possibility.

Recommendation 23: The Council, through the Chief Executive, should ensure that references for those working with children are retained in the employee's personnel file.

Recommendation 24: The Council, through the Chief Executive, should give guidance to employees on the provision of references, indicating who is authorised to provide them and the extent of inquiry before a reference is written. Employees providing references in a personal capacity should be required to make it clear that it is personal and should not write the reference on Council notepaper.

Recommendation 25: The Guidance referred to at Recommendation 24, should state that members of staff should not give references for clients which omit any mention of the nature of their relationship, even if that is now in the past.

H. Probationary period

9.92 As indicated above, the establishment of a probationary period for new employees was an element of the 1994 policy which was not implemented due to some resistance from the trade unions. The new processes accompanying the establishment of a Recruitment and Development Centre for Residential Child Care will address these matters through building in a 12 month period of temporary employment which will fulfil some of the functions of a probationary period. During this time, the employee will be subject to supervision and assessment by qualified practitioners. The offer of a permanent position would be dependant upon satisfactory completion of this stage.

9.93 In general, the staff we spoke to were in favour of a probationary period, although some concern was expressed that, if applied only to residential staff and not to field workers, it might provide a further disincentive to work in residential care.

9.94 It was also acknowledged that this was only a part of the process of safeguarding children, and that it might be possible for someone to “keep their nose clean” for a probationary period. Indeed, the Dean and Cauvin Trust has long had a probationary system in place, extending back to the time of some of the abuse. Probation has to be supplemented with proper supervision and appraisal and a willingness to address issues as they arise, through disciplinary procedures where appropriate.

9.95 Representatives of Unison expressed to us their view that child abusers were devious people who were unlikely to lower their guard during probation. They were not in favour of probationary periods for qualified staff. On the other hand, the Scottish Committee of BASW indicated: “We think there would be considerable benefit if all appointments were subject to a probationary period with a standard approach to appraisal.”

9.96 We acknowledge the fears expressed that a more stringent recruitment process might act as a further disincentive to those considering work in residential child care. However, we consider that it is also possible to see it as a way of raising the status of the job. The proposals for the Recruitment and Development Centre for Residential Child Care underline the critical importance of this work and the need to attract the highest calibre of staff. Those who expressed these fears to us linked them with the fact that residential workers already have worse pay and conditions. It seems to us that it is that area which has to be addressed.

9.97 We commend the intention of the department to pursue a 12 month trial period of employment. We remain concerned that it is designated as a period of temporary employment rather than as a probationary period proper, which is clearly acknowledged as the early stages of a permanent job. In our view, this both disadvantages the employee and has a potential negative impact on the safety of children. The disadvantage to the employee is clear in that the employment status is less secure. The safety implication lies in the fact that it is easier to dismiss someone from a temporary position without addressing the real issues. If an employee turns out to be unsuitable for work with children and young people, it would be better for all were that judgement to be brought into the open. The employee would be able to challenge it, and other children would be safeguarded by the existence of a record about it.

Recommendation 26: The Council, through the Director of Social Work, should discuss with the unions whether the existence of a proper probationary period in the context of a permanent contract, as opposed to a temporary period of employment, does not offer greater protection both for the employee and for the children and young people in residential care.

I. Training of Staff

9.98 The Skinner Report had recommended that 30% of all residential child care staff and 90% of all senior residential child care staff should hold a Diploma in Social Work or equivalent. 60% of residential child care staff should be assessed as competent at HNC/SVQ level 3.

a. The Director of Social Work’s written submission

9.99 This states:

In anticipation of the findings and recommendations of the Warner, Skinner and COSLA reports, a thorough review of the residential child care service in Lothian region took place during 1991. As a result of this review, a number of measures designed to improve the service were put before and approved by the Social Work Committee in December 1991. These measures included a range of improved training and development opportunities for residential child care staff, forming the basis of a five year training strategy. The main targets of the strategy were:

1. By 1997 all Unit Managers and Assistant Unit Managers to be qualified to a minimum of Diploma in Social Work.
2. By 1997 all Residential Care Officers to be qualified to a minimum of HNC/SVQIII.
3. All newly recruited Residential Care Officers to undertake Foundation (post induction) Training within six months of taking up post.
4. At least one Unit Manager per Unit to undertake the post-qualifying Certificate in Child Protection Studies.

9.100 This raises three questions:

- Are current targets being met?
- If not, why not?
- Are current targets appropriate?

b. Are Current Targets Being Met?

9.101 Whilst targets 3 and 4 above had largely been met and 1 had partly been met, there had been a significant shortfall with regard to other areas. All but two Unit Managers were qualified, but only 54% of Assistant Unit Managers were qualified (with a few more currently in training). Therefore 65% of the 57 managers and assistant managers would shortly be qualified to an appropriate level. Only 73 of the 220 Residential Care Workers were qualified, with another 39 undergoing training. When these have finished, 51 % of residential care workers will have qualified. The Scottish Office targets had therefore not so far been met.

c. If not, why not?

9.102 In the course of the public hearings, the Department's Training and Employee Development Manager suggested that the targets had been highly ambitious. They were not the wrong targets, but the mechanisms had not been there to achieve them. In her view the impact upon residents would relate to the quality of care they received rather than their safety.

d. Are Current targets appropriate?

9.103 We recognise that proposals are being drawn up which will affect the future of training for residential care in Scotland. We do not wish to pre-empt these, however many people have expressed views to us on this issue and we have drawn our own conclusions which we present here.

9.104 The identification of training targets is influenced by a number of considerations:

- the skills required for the job;
- the training needed to establish the skills;
- whether the job is to be regarded as a permanent career with a unique skills base, or whether it should be seen as part of a family of working opportunities with an expectation of movement between them;
- how one moves from the current situation regarding qualifications to the target identified; and specifically
- what should happen to current staff members who cannot or will not attain any new and higher standards.

The skills required for the job

9.105 Residential care may in the past have been regarded as a task involving domestic skills which were more or less innate in anyone with experience of family life. We noted in Chapter 3 that, at the time of Brain McLennan's leadership at Dean House, a marked change was taking place in the ages and needs of those coming into residential care. This presented a challenge to those running the organisation and an acknowledged need for greater professionalism. This situation was not unique to Dean House.

9.106 The question is whether all workers need to have a professional base, or whether there remains room for those with domestic skills not backed up by a grasp of theory. Does residential care involve one job (professional) or two (professional and practical)?

9.107 It is difficult for some staff to address this matter objectively, because they cannot avoid thinking of the impact on some current workers of requiring a fully professional staff, and the practicality even of achieving it. However, we believe it is important that the ideal is acknowledged and that targets are not set too low.

9.108 We do not accept the idea put to us by some consultees that there should be a lower class of worker charged solely with a caring role. This perpetuates the idea that caring in itself can be separated from the professional job. Residential Care Officers should be able to do both care and administrative tasks.

9.109 We therefore conclude that residential child care is a job requiring a professional qualification.

The training needed to establish these skills

9.110 The basic question is whether training for residential child care should be self-contained or based on a general social work qualification.

9.111 The Kent Report (at paragraph 3.4) reflected that "Training for residential staff has lurched around for decades." Separate training in residential child care had been dropped in the 1980s in an effort to match the residential qualifications to those of field work. In Kent's view, this had not worked. He said the result had been a largely untrained work force in residential and foster care. The small amount of training that did take place was based on a social work model that was not always appropriate.

9.112 Amongst Kent's recommendations was a suggestion (Rec. 22) that a new role of "social pedagogue" be created. This would involve building a child care qualification onto a variety of other professional qualifications such as teachers, nurses and youth workers, as well as social workers.

9.113 BASW Scottish Committee were more supportive of the general social work training as a basic qualification for residential staff. They said they would have concerns about introducing a course focusing exclusively on child care. Their view was that a significant proportion of care staff should be qualified social workers with basic, general training. They should also have specialist knowledge of the needs of children and young people. They also believed there was a core of skills and knowledge applicable to residential work with vulnerable groups. Specialist components could be available for post-qualifying training and to facilitate staff moves amongst different areas of work. This seems to imply a basic social work training, plus special courses in residential work with vulnerable people, and yet more specialised components on the needs of different groups, including children and young people.

9.114 The idea of a full social work training supplemented by specialist components was also attractive to the manager of a unit for children with special needs, who noted that, in that particular field, some of the skills which staff required were not transferable and could lead to members of staff becoming "stuck".

9.115 It seems to us that the views of Kent and BASW can be reconciled. We support BASW's contention that a "significant proportion" of residential child care staff should have a basic social work qualification supplemented by specialist components. However, there is also room for the concept of the "social pedagogue", bringing other professional skills into residential units.

9.116 The current minimum acceptable qualification for Residential Care Officers is HNC/SVQIII. Kent reported (at paragraph 6.2.3) the mixed feelings he had encountered about this level of qualification. We also encountered an ambivalent response.

9.117 Many of those we spoke to, including the Training and Employee Development Manager, thought the HNC/SVQIII was not high enough. There was also a view that it was not relevant enough and involved too much "paper pushing."

9.118 We agree that, as a long term target minimum qualification for residential care it is too low.

Should residential work be seen as a permanent career?

9.119 The Director of Social Work's written submission had indicated that staff turnover for Unit Managers and Assistant Unit Managers was higher than average, while that for Residential Care Officers was lower. The moving on of qualified staff was advanced as a possible reason for this. It seems that a problem in sharing the qualification with general social work within the current system is that, having obtained it, many residential workers

then move out into field work with its better pay and conditions. This means that the residential services do not derive the benefit of the time allotted to training.

9.120 Whilst any immediate moving on represents a loss to residential care, and adversely affects the achievement of training targets, the moving on, even of qualified staff, can sometimes be seen in a more positive light. The Kent Report expressed the view that work in residential child care should not be regarded as a “cradle to grave” career. It was a demanding job and more appropriate for those in the age span of normal parenting responsibilities. He said the training structure should be designed to allow workers to move in and out of residential care.

9.121 The BASW Scottish Committee agreed that it was desirable for staff to have the flexibility to move between settings to avoid the build up of stress which can sometimes be a contributory factor in abuse.

9.122 It seems to us that the possibility of movement between different aspects of social work and of residential care is something which should be encouraged. The problem at the moment is that the differential in pay and conditions between field and residential work disadvantages the residential system in terms of attracting and retaining qualified staff. It is this differential which has to be addressed.

Moving towards the target

9.123 There is no point in setting unachievable targets or impossible timescales. It has already been noted that the current targets, although felt by many to be too low, have still nevertheless proved to be difficult to achieve. BASW Scottish Committee told us that, as a fully qualified work force was not achievable in the short term, they welcomed the commitment to further training for residential workers.

9.124 Nevertheless, it is important that the ultimate target is clear. One Unit Manager explained his view, which draws together some of the issues outlined above:

Training for residential is patchy. They ought to be trained on a standard at parity with field workers. The problem is not just that the current standard for HNC/SVQ is not being met, but that it is too low. The SVQ is worse than the HNC because it is based on existing practice and therefore might be reinforcing old practice. The HNC/SVQ route might be essential for those currently in post, but a professional qualification should be required of new staff. It is a vicious circle; the current low status means that highly qualified staff will not apply. Something has to be done to break that circle. It cannot be done overnight, but the department needs to “set out its stall.” It needs a critical mass of qualified staff in order to attract more qualified staff. Salary scales also needed to be looked at. There is very little career structure and too many cross-over points in salaries.

9.125 We agree with this view.

Current, unqualified staff

9.126 A central dilemma was that insistence on a qualified staff would mean the loss of some current staff members who were well thought of. These were referred to as “gut level workers” or “rare gems.”

9.127 The department had endeavoured to provide training opportunities for unqualified residential care officers to attain the HNC/SVQIII required. Some had not been able to complete the course and obtain the qualification. Many had been in post for some years. Some had difficulty in relating to the educational demands placed on them, partly attributable to the gap in years since they had left school. The need for such staff to receive necessary support, assistance, time off and encouragement did not appear to have been consistently applied.

9.128 We believe there is a weighty responsibility on the department to ensure that staff are helped and encouraged to achieve this basic qualification.

9.129 The Recruitment and Development Centre programme envisages continued recruitment of staff who do not possess a professional qualification in social work. They are required to satisfy the Council about their ability through completion of a test which should ensure that they are capable of achieving the basic HNC/SVQIII qualification.

e. Particular concerns

9.130 With regard to the specific content of training, both Kent and Finlayson/Newman were concerned that it should address matters relating to the safety of children, such as safe caring, normal sex and sexuality, sexual abuse, paedophile behaviour and peer abuse. The Director of Social Work indicated during the public hearings that this recommendation of Finlayson/Newman (Rec. 8) had been implemented.

9.131 One particular concern we had was that teaching staff in Wellington School, which is jointly funded by social work and education, take over some care responsibilities at weekends without having received induction training to support them in that task.

9.132 Lessons 3, 31, 32, 33 and 75 above referred to the many behaviours engaged in by the children which might have drawn attention to the fact that they were being abused. This included name-calling, writing poems and later books, self harm and running away.

<p>Recommendation 27: The Director of Social Work should ensure that the training programme for residential and field work staff is designed to assist them to respond appropriately to behaviour by children which might be an indicator of abuse.</p>

f. Conclusions

9.133 It is clear that the Department has shown a commitment to training to get to the position where it has a well qualified staff. We are also aware that the department has shown a commendable commitment to upholding standards in the voluntary sector by making many courses available to their staff at low cost. However, it seems to us that the targets set by the department are both too low for the tasks, and too high to achieve in the real world, when staff and other resources are under pressure.

9.134 The SVQ is an assessment of competence. If a current worker fails to achieve it, that raises the question whether the worker is in fact competent. If the experience is that workers who are not just competent but good are failing the SVQ, then something must be wrong with the support and/or assessment structure.

9.135 We conclude that the HNC/SVQ should be retained as the minimum acceptable target qualification for current staff. There is a heavy responsibility on management to ensure that the “rare gems” are supported to take up the challenge of obtaining it.

Recommendation 28: The Council should aim to have a fully qualified professional staff in residential child care. We recognise that this is not achievable in the short term, and that consultations are ongoing about what the appropriate qualification should be. The Government’s Response to the Kent Report has addressed this issue as well as the implications for staff who remain unqualified.

Recommendation 29: Until the aim set out in Recommendation 28 is achieved, the HNC/SVQIII should be the minimum acceptable qualification. Staff with no qualifications should be given all appropriate opportunities and support to ensure that this qualification is obtained.

9.136 As indicated above, we are aware that proposals are being drawn up with regard to the future of training for residential care in Scotland. We have ourselves considered these issues and offer some reflections arising from our experience in undertaking this Inquiry. Given the wider consultation currently taking place, we feel it is not appropriate for us to raise these to the level of recommendations. We offer the following as a contribution to this debate.

9.137 In principle, we feel it should be possible to either start with a general qualification and convert it to one appropriate for residential child care, or start with a residential child care qualification and convert it to general social work, provided that flexibility is allied to a high standard of professionalism.

9.138 While the main task for the present is to improve the professionalism of those currently charged with the task of residential care, we believe there is some merit in Kent’s suggestion of the creation of a “social pedagogue” role, which should be considered in the context of the proposals referred to above.

J. Staff Supervision

a. The Director of Social Work’s written submission

9.139 This stated:

The Quality in Standards for Residential Child Care 1992 and the Quality in Caring: Standards for Services to Children, Young People and Families 1995 both contain minimum standards for staff supervision; at least one individual session per month for residential care staff and a minimum of two hours per month for social work practitioners respectively. These standards are underpinned by an expectation that supervisors will have undertaken relevant training in staff supervision and support.

The Finlayson/Newman Inquiry Report of 1993 recommended that a “Regional policy on supervision be implemented on a shared basis.” A policy was devised as a result of joint consultation but not formally promulgated. However, this policy does form the basis of the staff supervision training programme and is being followed within the Department.

9.140 The Director of Social Work indicated during the public hearings that there were some problems in maintaining supervision due to staff shortages.

9.141 Issues about supervision included:

- the frequency of supervision;
- its purpose;
- the recording of supervision sessions;
- ownership of supervision notes; and
- who received supervision.

b. Frequency

9.142 We were concerned that supervision seemed to be cancelled in many units more often than it took place. Those who had targets frequently failed to meet them. We had no sense that the department's policy on supervision (once per month) was consistently followed.

9.143 There was a consensus amongst staff that supervision, whilst valued, was "the thing that goes out the window when something else takes precedence." Many spoke to us about "informal supervision" or "corridor supervision" as a supplement which diluted the negative impact of the cancellation of formal sessions. Advice from a more senior member of staff with regard to a particular event was frequently classified as "supervision."

c. Purpose

9.144 Many saw supervision as an arrangement between the supervisor and supervisee designed to promote accountability, to support that individual's performance and to indicate areas for improvement and means for achieving it.

9.145 On reflection, it became apparent to some, that supervision was now taking on wider functions, which detracted from its character as a personal contract. Supervision notes had been found to be of relevance in disciplinary proceedings. Where appraisal systems were in operation, supervision notes made a contribution. The recently circulated "whistle blowing" policy on "Free Expression of Staff Concerns" had indicated that supervision sessions would be appropriate fora for staff to raise concerns about the treatment of clients. The Kent Report had gone further in suggesting that safety be a standing item on the agenda of supervision sessions and should be minuted as such. We also recommended (Recommendation 6) that supervision should encompass the supervisor checking out with staff that they were aware of policy and practice developments and that they understood the implications for them.

9.146 We also consider that supervision provides an appropriate opportunity for discussion with workers who will be leaving their posts about what requires to be done to ensure that there is a smooth transition. Lessons 38 and 54 from the past drew attention to the fact that, in some of the cases we looked into, significant difficulties had been caused by the departure of a worker, leaving some matters unresolved or files in a bad state.

Recommendation 30: The Director of Social Work should ensure that, as soon as a worker intimates that he will be leaving his or her post, supervision sessions should have a particular focus on the steps he or she is taking to ensure that matters are left in a satisfactory state to facilitate an easy handover. The supervisor should ensure that key tasks are identified and that the worker has sufficient time to carry these out.

d. Recording

9.147 Our enquiries disclosed a wide variety of practice with regard to the recording of supervision. Some were recorded and/or filed, and/or seen by the supervisor, some by the supervisee. Some were not recorded at all. “Informal” supervision was generally not recorded.

9.148 In the course of the public hearings, the Head of Operations indicated that the responsibility for recording sessions was agreed between the two people involved. He also agreed that informal supervision should be recorded.

9.149 We were aware that the department’s Personnel Services Manager had devised proposals to standardise the form of recording. We have now seen the proposed supervision record form. This is discussed further below.

e. Ownership of the Supervision Notes

9.150 This was an issue that not many people had considered. It becomes an issue when notes are needed in relation to an investigation or disciplinary matter, or when someone moves into other employment.

9.151 With regard to the former, the Kent Report had reflected on the fact that the “plethora of investigations” into past events reinforced the need to retain files that might become significant. He recommended (Rec. 21) that staff files should be kept for a substantial period, probably not less than 25 years. We agree that supervision notes might well become significant and therefore ought to be retained.

9.152 With regard to the latter, it seemed that there was no clear policy with regard to what should happen to the notes when either the supervisor or the supervisee left the employment of the Council.

9.153 These issues raise the question of ownership of the notes. During the public hearings, both the Director of Social Work and the Head of Operations volunteered the view that supervision notes were the property of the Council. They agreed that it might be necessary to reinforce this matter.

f. Who received supervision

9.154 We were concerned that there were gaps in the supervision structure. Some managers received no supervision. Locums receive limited on-site supervision, although there are plans to improve these arrangements through appointment of officers associated with the proposed Recruitment and Development Centre for Residential Child Care. Education staff at Wellington School receive no supervision with regard to their care responsibilities.

9.155 We were also concerned that a facility used by the Council outwith Edinburgh appeared to have no supervision structure in place. Staff did not seem to know what supervision was.

g. Current Developments

9.156 We received from the department a proposal from the Personnel Services Manager dated March 1998 which set out minimum standards and frequency of supervision and a sample form for recording supervision sessions. An update in October 1998 showed that the standards which had subsequently been approved fell short of those recommended in March, and indeed fell short of the frequency set out in the Quality Standards documents referred to in the Director's submission. The Quality Standards document had recommended, for residential care workers, one individual session per month. The March 1998 proposal was for one hour every four to six weeks. The standard subsequently approved was "up to one hour" to take place at a minimum frequency of six weeks. The document adds that this supervision would be in addition to any agreement or plan for group supervision or informal supervision. In subsequent discussions, the Department has indicated that the words "up to" have now been deleted. We welcome this amendment. The phrase "up to one hour" for residential staff would be meaningless. It almost suggests that that would be an upper maximum and would permit supervision of much shorter periods than one hour. Five minutes could be "up to one hour."

9.157 The proposals for a "supervision record" are attached to the document. The format of that record is such as might serve to undermine the importance of the subject. The record consists of one page. It includes a requirement as to the proposed date of the next session and the need for the document to be signed by the staff member and supervisor. The amount of space allocated to other headings and especially that of "summary of sessions" is not such as to allow full development of the subject matter to be recorded in any detail. If, as we hope, supervision becomes a practice which makes a major impact in staff professional development, this appears inadequate in terms of reflecting the content of supervision.

9.158 Whilst we recognise that the frequency stated is a "minimum" frequency, it is our view that, given the temptation to set supervision aside when other matters require attention, this sends the wrong message about the importance of supervision. Residential child care is a complex task require the highest standards of professionalism and oversight. In our view the very minimum acceptable standard would be one hour every four weeks.

Recommendation 31: The Director of Social Work should revise the department's policy on supervision to require a minimum of one hour every four weeks for residential child care workers. If a session is cancelled it should be rearranged. Every worker should receive at least 12 supervision sessions each year.

Recommendation 32: The Director of Social Work should reconsider the format of the form for recording supervision in terms of the space available for information to be inserted.

h. Conclusions

9.159 Supervision is not just about personal accountability or personal development; it is essential to maintaining and developing the high standards of professionalism that create safe working systems. There should also be an expectation that it provides a forum (but not the exclusive forum) in which staff can express any concerns impacting on child safety.

9.160 We reflect throughout our report our recognition of the complexity and sensitivity of the responsibilities that fall on residential staff and the need for them to have appropriate opportunities to develop their competence and skills. We stress the need for these staff to be as well qualified and respected as their colleagues in field work in child and family teams. At present a substantial number of residential staff do not have the level of professional qualifications of their field work colleagues. That perceived differential could, so long as staff are “unqualified,” best be met by increasing the amount of training and supervision which is provided for these staff. We find it anomalous that field work staff, all of whom are professionally qualified, are expected in terms of the document to which we have referred to have supervision on more occasions and for longer periods than is the requirement for their residential colleagues. For field staff the minimum is once per three weeks for “one hour and thirty minutes.”

9.161 For supervision to be as effective an aid as we envisage, we believe that one hour is the very minimum period that should be allocated to the task. Such a period would be necessary for development of an agenda, reflection on practice and experience, examination of alternatives, addressing weaknesses, building on strengths and generally increasing confidence and ability. Such an agenda would make appropriate demands on both supervisors and staff. Supervision sessions as envisaged above would require to be recorded in such a way that the written record provided a stimulus for improved professional practice and form a basis for constructive annual appraisal and a medium for positive professional development.

9.162 We have reflected earlier that we do not see “informal supervision” as a substitute for individual supervision sessions. Nor do we consider group supervision to be an appropriate substitute. We appreciate that residential staff face many demands and that there may be concerns as to the practicality of meeting the targets which we suggest would be appropriate. For many Units, when the children are at school during the day, we have difficulty in accepting that greater efforts could not have been made to ensure that planned supervision sessions actually took place and were rearranged in the event of cancellation. Further, we recognise that those who supervise will require training and support to enable them to discharge their duty effectively and on a consistent departmental basis. Basically, we consider the whole issue of supervision to be an urgent priority for the department.

9.163 Whilst we understand the pressure of work demands, we recommend:

Recommendation 33: The Director of Social Work should ensure that supervision is placed much higher on the list of priorities for residential child care staff. Child safety should, as Kent suggested, be a standing item on the supervision agenda.

Recommendation 34: The Director of Social Work should ensure that achievement of supervision targets is reviewed annually by unit managers and the results considered in the context of the manager's appraisal.

Recommendation 35: We recommend that, where a contact between members of staff is identified as supervision, it should be recorded at the next formal supervision session.

Recommendation 36: Supervision should be distinguished from requests by staff for opinions, advice and guidance from their seniors. A requirement to record such requests could inappropriately discourage staff from asking for advice or responding to such requests.

Recommendation 37: Supervision notes should be declared to be the property of the Council, and should be maintained within the Unit. They should be transferred to the staff member's personnel file when he or she leaves the Unit.

K. Staff Appraisal

9.164 The Personnel Services Manager indicated in the course of the public hearings that performance appraisals were being introduced throughout the Council. This would form part of the overall supervisory framework, in which supervision would be seen as a right. Standards for appraisal were currently being drawn up.

9.165 We encountered some positive response from staff to the idea of an appraisal system. Some thought it had a particular importance in respect that the new Recruitment and Development Centre would not have an immediate impact. They believed there was a need to find a way to help some people move on who were either not suited to the task of residential child care or who were "burnt out." This was not necessarily related to how well qualified they were. The following are some comments by staff:

Some staff have been there a long time. They have draconian attitudes towards children. It's not about qualifications; it's about values and attitudes.

Power relationships within units are inconsistent with qualifications and skills. Some RCOs have better qualifications and skills than their managers and supervisors.

There are people that the system really needs to get rid of. Some units have inherited a staff team where the AUMs are not up to the task. The problem is that people at that level without qualifications can't move on.

If I was allowed to do it, there are people I would want to get rid of. They are not necessarily dangerous, but are ineffective as workers. Young people are aware of this. It would take too long to wait for natural wastage. Kids in units need and deserve the best staff, and we've not got it.

9.166 Some staff spoke to us of "loose cannons" about whom there were concerns, but nothing concrete enough to do anything about. One manager from a voluntary organisation described her past concerns about such a person. However, as she put it: "The employment thing was really difficult." The person remained in post and was later sacked for assaulting a young man.

Before that, there had been nothing to get rid of him on, but all the indicators were there.

9.167 In our view this is the kind of matter which could best be dealt with by a probationary period followed by appropriate supervision and honest appraisal, which has already been discussed above. We were concerned to discover that in a recent disciplinary case leading to dismissal for inappropriate behaviour, the employee concerned reported that he had received an excellent annual appraisal and had been offered extra twilight and night shifts which would have given him greater opportunity for abuse.

9.168 Whilst these concerns cannot be ignored, it is also necessary to avoid appraisal being seen as a threat to staff who may feel insecure. The view was expressed above with regard to training, that residential work should not be seen as a cradle to grave career. Moving on should become an expectation, and appraisal should be seen as a way of identifying when it is time to do so. Self-appraisal as part of the overall process could help promote this perspective. It would provide workers with an opportunity to identify what support they needed to allow them to continue in the job, or what training they needed to help them move into other areas of work.

9.169 Many of the staff responses focused, as indicated, on the negative use of staff appraisal, i.e., to get rid of staff not up to the task. Such a limited perspective is unfortunate. Consistent staff appraisal provides a valuable opportunity to enhance professional abilities and provide job satisfaction. Targets can be set, practices improved, confidence developed, and overall competence achieved.

9.170 We encourage the Department to proceed with implementation of proposals for a more comprehensive appraisal system which will focus on the positive benefits for individual staff members.

L. The Locum Bureau

9.171 The Director of Social Work's written submission stated [2.1.3] that the Locum Bureau was established in response to the Finlayson/Newman Report of 1993. This had given a local impetus to the earlier recommendations of Warner and Skinner. The Bureau was established in January 1994 with a remit to manage a register of approved Locums for short term and emergency cover.

9.172 The Bureau operates a rigorous selection process involving psychometric tests and personality questionnaires. Approved candidates are required to attend a three day induction course. In the course of our enquiries we encountered people who had been through the selection process, including a student on placement who had been rejected by the Bureau as not, at that time, having sufficient experience. These people confirmed that the selection process had been demanding. The Bureau itself informed us that a recent recruitment exercise resulted in 8 out of the 20 applicants being selected. On a previous occasion, 120 people had expressed an interest, 46 completed application forms, 19 had been interviewed and 5 had been selected.

9.173 Prior to local government reorganisation, the Bureau operated seven days a week with late opening from Monday to Friday. Since reorganisation, reduced resources had made

it necessary to restrict its operation to normal business hours. When the Bureau is closed, Units make direct contact with approved and registered Locums.

9.174 Issues that have arisen with regard to Locums include:

- Numerical pressure on the Bureau
- Units making direct contact with favoured Locums
- Difficulties experienced by specific units with special needs
- Lack of continuity
- Dealing with concerns about Locums
- Access by voluntary organisations.

a. Numerical pressure on the Bureau

9.175 There are 89 Locums currently registered for work in children's units. Only 20 to 30 of these are regularly available for work. A few are virtually full time. Students provide a useful resource for the Bureau.

9.176 The Bureau is not always able to supply a Locum for a unit requesting one. This means that unit staff have to work overtime to an extent which can sometimes be excessive.

9.177 It seemed to us that some Locums were working regular hours and were basically integral to the staff complement of their unit. However, this disadvantaged them in respect that they had no rights to holidays, and disadvantaged everyone, including the children, in respect that they received no supervision from unit staff; a matter which was noted with concern in the discussion on supervision.

9.178 Proper staffing levels would reduce the calls on the Bureau. The Director of Social Work's written submission had indicated that, as a result of budget cuts, a "performance factor" had operated on the staffing budget, with the result that vacancies in children's homes had been unable to be filled. This had increased the levels of temporary staff and disrupted key worker relationships with children. In our view, this is completely unacceptable.

9.179 When a child is in the care of his or her family, no court would accept the existence of competing priorities as an excuse for inadequate levels of care. When a local authority takes over the care of a child, it has at least the same, and arguably a higher, responsibility. The safety of children looked after by the Council must be regarded as a top priority in the allocation of resources. "Performance factors" are irrelevant and inappropriate.

b. Units making direct contact with favoured Locums

9.180 Some staff reported that having an unknown Locum was sometimes more trouble than it was worth, although it might be necessary in order to "keep the numbers legal." They preferred to build up a relationship with a trusted few and to contact them direct. Some would wait until business hours were over to justify this. Some would check that their favoured Locum was available and mention this when contacting the Bureau.

9.181 We recognise that, where a Unit staff have confidence in a particular Locum worker and know that person relates well to their residents, there is merit in them seeking to obtain that Locum's services.

9.182 Units that did not have to use Locums often, felt at a disadvantage in not having a favoured pool to dip into. One Locum contacted us to complain about the way in which Units undermined the bureau and disadvantaged some Locums by making direct contact with others.

c. Difficulties experienced by specific units with special needs

9.183 Staff expressed the view that, while Locums might be able to operate generally at a satisfactory level, the Bureau was not able to supply people with the ability to deal with units with particular needs, such as secure units or those working with younger children. Staff in these units also felt this justified them in contacting favoured and trusted Locums direct. For example, they expressed understandable concern about bringing strangers into night work with younger children.

9.184 The Bureau's view is that they do attempt to match specific needs but are often unable to do so because of lack of staff.

d. Lack of continuity

9.185 As discussed above with regard to time lags experienced in obtaining SCRO checks, the Bureau provides only short term and emergency cover. It cannot guarantee any continuity.

e. Dealing with concerns about Locums

9.186 Units report concerns about Locums to the Bureau, using evaluation sheets. These are issued for the initial shifts of all new Locums. They are also issued when concerns have been expressed about a Locum. It was suggested to us that some staff are reluctant to express their reservations about a Locum on paper, preferring to make vague verbal allegations. On the other hand, staff of two units expressed concerns about how reports on unsatisfactory Locums had been processed. We describe below the two cases, as well as one which raises a concern about recruitment in a particular case, when the usual rigour seems not to have been applied.

9.187 One unit commented that, while they understood that a person they had expressed concerns about no longer acted as a Locum, the process of taking him off the books seemed to take a long time. They speculated that the response to low level concerns might be that the Locum remained on the books but was not generally used. However they suspected that some units might end up having to take them in an emergency because no-one else was available.

9.188 Another unit appointed a member of staff who had previously been a Locum. After a very troubled period involving concerns about inappropriate behaviour, it emerged that concerns had been expressed about him during his period as a Locum. They said they had heard that staff in other units would not have him back because of the strength of feeling

about him. Yet, they said, none of these concerns was passed on when the unit appointed him to a permanent post.

9.189 Further, despite the recognition above of good practice with regard to recruitment, a voluntary organisation told us that a person they had sacked for inappropriate physical restraint of a child had subsequently been employed by the Locum Bureau. The voluntary organisation had not been asked for a reference prior to his appointment.

f. Access by voluntary organisations

9.190 Voluntary organisations providing residential child care also experience difficulties with temporary cover. They attempt to build up their own pools of approved temporary staff. Some rely heavily on students. Some of the young people commented on the fact that some temporary staff were students who wouldn't talk to them and seemed afraid of them.

9.191 Whilst acknowledging that independent organisations have their own responsibilities for providing adequate staffing, we do consider that there would be merit in allowing specified voluntary organisations within Edinburgh who are caring for children from the city to have access to the Locum Bureau. During the public hearings, the Personnel Services Manager agreed that there was merit in this suggestion.

g. Conclusions

9.192 The Locum Bureau has been a positive development and in most respects appears to work well. It is to the Bureau's credit that it has resisted the temptation to lower its standards in the face of staff shortages, although it may be that some Locums who are not very satisfactory are retained for use when nothing else is available.

9.193 Having been convinced that the recruitment processes for Locums were rigorous, we were concerned at the report referred to above that a Locum sacked from a voluntary organisation was recruited without a reference being sought from that organisation. We suggest that, in order to identify any weaknesses in the system, the department investigate how this could have happened.

9.194 While we would not wish staff to be inhibited from expressing concerns by the requirement to commit them to writing, we believe it is not satisfactory to rely on vague, verbal allegations, on which the Bureau would be unable to act. It should be made clear that expressions of general unease can be communicated on the evaluation forms and that an opportunity will be given to explore the possible cause.

Recommendation 38: We recommend that the filling in of evaluation forms be deemed mandatory in relation to the first five shifts of new Locums and for all Locums when serious concerns have been experienced about them.

9.195 Locum Bureau staff should be available to cover short term temporary absence such as illness, but should not be used as a substitute for permanent appointments.

Recommendation 39: We recommend that Locums should not be used to cover vacant posts, other than to provide immediate cover until a short term/temporary contract can be arranged.

9.196 Proper staffing levels would reduce the calls on the Bureau. The safety of children is compromised by the application of the “performance factor” to the staffing of residential units which requires the department to leave posts empty in order to meet target budget cuts.

Recommendation 40: It is our clear view that it is unacceptable to compromise the safety of children by requiring that some posts remain unfilled in order to cut costs. We therefore recommend to the Council, in the strongest terms, that residential child care units be exempted from the application of the performance factor in relation to staffing.

9.197 We are aware that the Bureau basically needs more Locums and that recruitment is a continuous process. Continuity would be an advantage, especially where it relates to night staff for younger children.

Recommendation 41: Recognising the advantages for units of building relationships with particular Locums, we recommend that this should be recognised as a legitimate and appropriate use of Locum Bureau staff.

Recommendation 42: In particular, we recommend that the Locum Bureau managers respond as positively as possible to requests by units for a Locum of a specific gender where this is relevant to achieving an appropriate gender balance in the unit or otherwise addressing an issue of safety.

Recommendation 43: We recommend that specified voluntary organisations be given access to the Locum Bureau.

M. Residential Care - General - Main Themes

9.198 The Director of Social Work is well aware of many of the areas in which residential care falls short of the standards expected, some of which are related to scarcity of resources. Whilst there can be some reallocation and gains to be made from a corporate approach, there is no easy answer to the need for more resources for looked after children.

9.199 From the safety point of view, recruitment of staff is clearly an area of great concern. The report has considered with approval the recent decision to set up a Recruitment and Development Centre for Residential Child Care Staff. This addresses many of the concerns we set out in this chapter which were also a central focus of concern of those victims of past abuse who spoke to the Inquiry Team.

9.200 A major concern with regard to staff was that the level of supervision did not match the department’s expectations. Nor were there clear and shared expectations about the purpose and recording of supervision. Our recommendations follow from our concern that it be made clear that proper supervision is a priority. Expectations with regard to supervision need to be clarified.

10. DEALING WITH DIFFICULTIES

A. Introduction

10.1 This chapter of the report looks at how allegations relating to the safety of looked after children are investigated. It also considers the methods available for staff to communicate concerns impacting on the safety of children, as well as the guidance given to them on issues of care and control and responding to children who abscond.

B. Investigation and Staff Discipline

10.2 Allegations that employees or substitute carers have abused children can come to light in different ways and can set in motion a number of processes regulated by different procedures:

- Child protection guidelines
- Complaints procedure
- Criminal investigation
- Disciplinary procedure
- Registration and inspection and/or approval of substitute carers.

10.3 As discussed in Chapter 5 and indicated by Lesson 77, the decision not to prosecute does not absolve the Department from considering the appropriateness of undertaking its own investigation.

10.4 The Director of Social Work's written submission [3.4.1] sets out how these procedures should relate to each other in any particular case:

Section 6.2 of the Council's Child Protection Guidance sets out the action that must be taken whenever an allegation is made by a looked after child. Such allegations must be dealt with under child protection procedures. This ensures that the child's safety takes precedence over complaints or disciplinary procedures. Complaints and disciplinary procedures are suspended while child protection procedures are investigated.

10.5 Children and Families Practice Notes/Guidelines, issued in September 1997, add:

The Child Protection Guidelines will be followed by Social Work, Police and Health Education staff before the application of any other process.

For example, any disciplinary and complaints matters will be dealt with after the need for any child protection measures has been considered and, where necessary, carried through to the point where the child can feel as secure as possible.

The Council also has a duty of care towards the employee or carer and will also need to pay immediate attention to their employment arrangements (or family/household arrangements, if carers) and consider whether interim changes ought to be made to these arrangements.

10.6 The 1997 document sets out a very detailed and balanced approach to the investigation of allegations against employees or carers. It regards the welfare and needs of the child as paramount; but also recognises the need to treat employees fairly. Later on in this report, at Chapter 18, we address the perception by residential child care staff that they are not

valued, and the implications of this for the safety and welfare of children. It is important, for everyone's sake, that their own rights are upheld throughout the process.

10.7 An allegation against a member of staff within a residential unit, whether justified or not, has an immediate impact upon relationships. Until matters are resolved, staff might feel wary of any contact with the young person involved lest they also become implicated. The member of staff who is the subject of the allegation may feel wary of contact with the complainant, and indeed with other young people in the Unit in case it is misinterpreted. The response to this situation must primarily be protective of the residents, but it may also be necessary to protect the employee from exposure to further allegations, and to take pragmatic steps to ensure the smooth functioning of the Unit.

10.8 The 1997 guidelines set out a range of responses which the manager charged with conducting the child protection investigation must consider. The employee involved might: -

- continue all of their present duties;
- continue some of their present duties;
- be transferred to other duties;
- be transferred to another Unit (or another part of the same Unit if it is very large); or
- be subject to precautionary suspension.

10.9 The guidelines say that precautionary suspension is to be used only where the staff member's duties or place of work could not be changed without risk to children or without impeding the inquiry, or where the allegations are so serious that prosecution and/or dismissal for gross misconduct is a possibility.

10.10 Where the allegation is judged to be unfounded, or the results are inconclusive, the document suggests consideration of mediation and counselling for the people involved. It also recognises that there may be a need to consider the advisability of further contact between the parties.

10.11 At the other end of the scale, if a prosecution is to follow, the guidelines say that disciplinary action need not wait until the criminal proceedings are concluded. There may however be concerns on the part of the Fiscal if the evidence for the prosecution were to be "rehearsed" in the course of disciplinary proceedings. The document advises:

In some circumstances, there may be wider concerns about the employee's behaviour which means that the conclusion of disciplinary proceedings does not depend on the outcome of a criminal trial.

10.12 We comment below on issues arising out of this.

10.13 The 1997 guidelines indicated that investigations in relation to disciplinary procedures should be conducted in a way that builds upon the information gathered from the processes that went before, and avoids the need to re-interview the child or question him or her in formal proceedings. Complaints procedures would be progressed only "after considerations about prosecution or disciplinary action." This clearly raises the question about how the complainant is to be kept informed of progress on the concerns raised in the

complaint. This matter is discussed further in Chapter 12 in the context of feedback on complaints.

10.14 The 1997 guidelines say that the outcome of any investigations should be notified to the significant parties, which may include the original referrer. A number of other people require to be notified.

10.15 There is clear guidance in the 1997 guidelines about what information is to be retained and where it should be located. This is discussed further below.

10.16 The following list indicates issues which have come to the attention of the Inquiry and which we consider relevant to our remit: -

- a) Physical contact
- b) Precautionary suspension
- c) Support for the Child
- d) Who investigates?
- e) Feedback
- f) Retention of information
- g) Resignation before investigation complete
- h) Involving the police
- i) Employee's rights taking over later in the process
- j) Allegations of historical abuse
- k) Complainers/victims with special needs
- l) Involvement of child protection co-ordinator

a. Physical Contact

10.17 A young woman, who had been in several Units over the years, told us how interactions between staff and residents had changed over the years. Before "all the talk about abuse" she used to ask staff for a massage, or they would tickle her. All that had stopped. They might put one arm around you, she said, but not two.

Members of staff are feart to give you a cuddle in case you took it the wrong way. When I used to get really upset I would want someone to be there and give you a cuddle.

10.18 The Kent Report (Introduction) had commented on this dilemma:

If child protection is the driving force rather than child care we may create a safe climate that is also a sterile climate. I have been saddened to hear of quite recent incidents of physical and sexual abuse. I have also been troubled to find that some carers in homes, schools or foster homes are now frightened to put an arm around a child.

10.19 This is relevant to the consideration of care and control which follows; but it is also relevant at this point in relation to the response to allegations. We refer to the dilemma at this point in our consideration of investigation of allegations as a reminder that balancing the scales too much in favour of protection can create a climate of fear, and an avoidance of care in its truest sense, which will ultimately work to the disadvantage of children and young people.

b. Precautionary Suspension

10.20 The Council's procedures acknowledge that the primary need is to protect children looked after by them. The 1997 guidelines set out a range of possible responses to allegations and recognises the need for judgements to be made throughout the process.

10.21 Judgements at this stage will be based on a risk assessment of the situation rather than on an assessment of the truth of the allegation. However, no matter what the actual criteria, there is a danger of this judgement being seen as a pre-judging of the merits of the case. An automatic suspension involving no such judgement avoids this difficulty but may be experienced as too harsh and over-reactive and open to manipulation. There was a feeling amongst some staff that a procedure involving automatic precautionary suspension would become known to the young people and would give them inappropriate power over staff. This would have a knock-on effect upon relationships between staff and residents. It did not sit nicely with encouraging staff to avoid fear-driven, clinical interactions with children and to engage in appropriate physical contact.

10.22 In the course of our enquiries, we spoke to a female resident who had been the subject of an allegation by another resident that she was involved in a sexual relationship with a member of staff. The young woman told us that the allegation was completely untrue and was subsequently withdrawn. In the interim, the member of staff had been suspended pending investigation. This had caused her considerable anguish as she considered the effect on his wife and family. It was also very awkward for both of them when he returned to work.

10.23 We recognise that, while communications advising of suspensions spell out very clearly that no presumption of guilt is implied, the effect of such decisions on staff and their families can be devastating. Rumours of the "no smoke without fire" variety vie with expressions of support and disbelief.

10.24 Staff are concerned about the possibility of false allegations. Giving inappropriate weight to this fear would seem to involve collusion in an approach based upon a perception that children commonly lie about abuse. This would be a particularly inappropriate response for an Inquiry charged with learning lessons from a past in which children were allowed to suffer abuse because nobody believed them when they tried to tell.

10.25 Research would appear to indicate that the chances of being the victim of a false allegation are very slight. However, in the current climate, that is unlikely to cut much ice with adults who fear finding themselves one of the unfortunate few.

10.26 We suggest no amendment to the 1997 guidelines with regard to the range of responses to allegations. It is appropriate that there is some sort of discretion involved in the response. However, the perception and experience of staff is that suspension is an automatic response. Although this may seem the safer option on paper, that is not always the case. Apart from the impact on the worker, a suspension regarded as unfair can put the child involved in an intolerable position, and subject that child to pressure from other residents and possibly staff.

10.27 We recognise that, no matter what is said about it not being a pre-judgement, suspension brings a tarnish on the reputation of the worker involved.

Recommendation 44: The Council should recognise that the safety of children in residential units is dependent upon them being cared for by an able, confident, secure staff team; that suspension of any staff member can adversely affect children's security; that consideration should always be given to the possibility of alternative employment for the staff member during the period of investigation; and that every effort should be made to complete the investigation at the earliest possible date. We therefore recommend that the full range of managerial responses to allegations of abuse set out in the 1997 Children and Families Practice Notes/Guidelines be explored and utilised where appropriate. The reasons for the decision to choose one response rather than another need to be clearly articulated and recorded.

c. Support for Children

10.28 The Finlayson/Newman report recommended:

“26. We recommend that when a child has made an allegation of abuse, a decision be taken to identify a key individual who would have paramount responsibility to provide appropriate support to the individual child.

27. When judicial proceedings arise from an allegation, we recommend that the key individual providing support to the child should provide appropriate support before, during and after the judicial proceedings.”

10.29 The Finlayson/Newman Report considered that the individual referred to in these recommendations would have a key role in identifying whether the interests of the child required removal from the unit while the investigation was proceeding.

10.30 The Social Work Department's Plan of Action following on from Finlayson/Newman gave a number of groups and individuals the responsibility to pursue implementation of Recommendations 26 and 27 by “ensuring clarity of responsibility in procedure on investigations.” The Director of Social Work's report on progress on implementation of the Finlayson/Newman recommendations, which was submitted to the Inquiry in connection with the public hearings, indicated that the principles underlying these two recommendations had been fully agreed. In terms of translation into practice, the 1997 Child and Family Practice Notes/Guidelines (paragraph 3.4) say that, at an early stage in the

proceedings, a social work manager must be given the task of ensuring that the child's best interests are safeguarded, usually through the child's allocated social worker.

10.31 The need for proper support for a child involved in such investigations was highlighted in Lessons 34, 50, 59, 63 and 68 relating to the past. In our view, the safeguarding of interests and the provision of support are not identical activities. In response to questions at the public hearings, the Director indicated that, where allegations were made, children were supported by their own social worker and possibly also by the Children's Rights Officer and other members of the care team. He noted that this was not written down in a way that set out clear expectations, but there was in practice an expectation that the child's social worker would provide this support. He said that he could not honestly give an assurance that there had been no case in which a child had been left unsupported.

10.32 With regard to Recommendation No. 27, it was reported that this judicial aspect had not been fully addressed as the child witness programme across Scotland would be relevant in Edinburgh too. The development of support for vulnerable child witnesses in court means that support in judicial proceedings is often delegated to those experienced in this area of work. We have had some contact with the social workers operating in a supportive capacity at the High Court in Edinburgh and were impressed by their dedication and commitment. We have not investigated the support available in sheriff courts. We believe it is important to ensure that support is always provided and in as consistent a way as possible. The key individual identified above should still have a role in ensuring that the child has such appropriate support during judicial proceedings or providing it him or herself if appropriate.

Recommendation 45: We recommend that the 1997 Children and Families Practice Notes/Guidelines be amended to set out the clear expectation that the task of ensuring that the child's interests are safeguarded includes the provision of appropriate support for the child. This may well be appropriate for the child's own social worker, but there should be a discussion with the child about who the child feels happy to accept such support from, and considerable weight should be given to those views in identifying the source of support. The child must always be given the option of independent support.

Recommendation 46: Notwithstanding the welcome development of programmes to support child witnesses within court settings, we recommend that the individual identified to provide support in accordance with Recommendation 45, should also ensure that the child has appropriate support before, during and after judicial proceedings.

d. Who Investigates?

10.33 The Finlayson/Newman Report (Rec. 17) had recommended early identification of a person to carry out the investigation, and monitoring of enquiries to ensure consistency. It had also emphasised (Rec. 18) the need to demonstrate the independence of the investigation by including someone from outwith the District in the investigating team.

10.34 The 1997 guidelines set out who should conduct the child protection aspects of the investigation. The department draws upon its own managerial resources for this purpose. However, in order to avoid a conflict of roles or responsibilities, the guidelines state that no-one involved in the investigation should be involved in line management or support and counselling of the person being investigated.

10.35 Involvement in investigations for other units is regarded as a task ancillary to the normal responsibilities of all unit managers. The Director of Social Work's written submission indicates the extent of recent training for managers to help them deal with these matters. A resource pack for investigating officers was also being developed. This largely implements recommendations 16 and 17 of the Finlayson/Newman Report.

10.36 The manager of one facility expressed his view that it was unsatisfactory to rely on other unit managers to carry out such investigations. "I have neither the time, the inclination nor the training to carry out that function." He thought the Council should employ its own investigating team for allegations, along the lines of the "arm's length" inspection team. It could look at other issues, such as financial irregularities, as well as abuse. It could involve employees who had another function that could be dropped when they were called upon to carry out an investigation. In the course of our work, we recognised that investigation of allegations, which is a time-consuming exercise, has placed heavy burdens on senior managers and can detract from their abilities to devote the time they require to carry out the tasks for which they were appointed.

10.37 Unison also indicated during the public hearings their view that there were too few senior managers within the department to undertake investigations. They suggested that separate, designated officers should be put in place to do this.

10.38 These problems associated with an ad hoc approach to the appointment of investigating officers were discussed with senior social work managers. They responded that the difficulty with having permanent investigating officers was that they became removed from practice. The department was however in the process of appointing a personnel officer who would work with colleagues in conducting investigations. This would be consistent with Recommendation 20 of the Finlayson/Newman Report which had recommended early and ongoing consultation by the investigating officer with the Senior Employee Relations Officer.

10.39 The Registration and Inspection Unit would be notified of the outcome of the investigations.

Recommendation 47: We welcome the recent efforts of the Department to train its managers in investigation and to relieve some of the burden upon them by the appointment of a personnel officer with a responsibility for investigation. We recommend that the allocation of roles between the manager and the personnel officer should be such as to recognise that the manager's main function is to contribute the perspective of contemporary practice, while the personnel officer carries the brunt of the investigatory tasks. Rather than an investigation by a social work manager with consultancy from a personnel officer, these roles should be reversed. We further recommend that this matter should be kept under review to ensure that managers are not diverted from their main responsibilities.

e. Feedback on Investigations

10.40 The Finlayson/Newman Report had recommended (Rec. 23) that "the authority, in co-ordinating investigations of this kind, should ensure that the young person is kept informed of what is happening and of the eventual outcome of the matter."

10.41 The general issue of feedback regarding complaints is addressed later in this report. Our concern at this point is with the complications caused by the intervention of other investigative processes, for example, child protection, disciplinary, or criminal investigation.

10.42 The character of other investigations can affect the feedback to the young person. If the child makes a complaint, but such other investigations are involved, the complaints procedure will be suspended until these are concluded. The results of these investigations may not be given to the child or young person for reasons, for example, of employer-employee confidentiality. The Finlayson/Newman Report had acknowledged these difficulties, but concluded:

Young people need to know the results of their complaints. Further, where the Department reaches the conclusion that the Department, through the actions of a member of staff, has caused harm to a young person, it appears to us to be crucial that the Department acknowledge that responsibility to the young person. Failure to do so may impede the task of continuing appropriately to care for the young person. We recognise that such a practice might conflict with the advice given by the Region's Insurers and by Legal Services.

10.43 In the course of the public hearings, the Director of Social Work updated the Inquiry on progress with implementation of the Finlayson/Newman Report. With regard to feedback to complainants, he indicated that implementation was partial.

Some young people do not feel they are given enough feedback on outcomes. There may be conflict with ongoing investigation process if information is divulged too early.

10.44 Until recently, the possibility of feedback to the young person in these situations was further affected by the fact that the Complaints Officer herself received no feedback on the results of other investigations. She reported during the public hearings that new procedures now required that she be informed of the results of relevant disciplinary investigations. She would not necessarily feedback to the complainant exactly what had happened as a result, because issues might arise of employer-employee confidentiality, but she would tell them that action had been taken.

10.45 The Director of Social Work has acknowledged that there is a need to examine the situation that arises when the complaints procedure is sisted to enable the disciplinary procedures to be followed through, and the implications for feedback to the complainant.

1. Allegations might not surface as complaints. Feedback through the complaints procedure is dependent upon the allegation being processed through the Complaints Office. The Children's Rights Officer told us that it was possible that an allegation of abuse by a carer might not arise in the form of a complaint, and might not be transmitted either to her or the Complaints Officer.
2. This possibility might seem to be covered by the 1997 guidelines which say that the outcome of any investigation, allegation or complaint must be notified to significant parties, which may include the original referrer and the parents or guardians of any child involved. However, the child might not have been the original referrer, and there is no specific requirement to inform the child appropriately of the outcome of the investigations.

10.46 We express concern that children and young people have not always been kept informed of the progress and outcomes of processes arising from incidents involving themselves.

Recommendation 48: We recommend that provision of feedback to children and young people, and the form it takes, should not be dependant upon the way in which the allegation arose. We reiterate the recommendations of the Finlayson/Newman Report in this respect and suggest monitoring of satisfaction levels of young people regarding feedback on allegations, no matter the procedure through which they are processed.

f. Retention of Information

10.47 The 1997 guidelines set out what information is to be retained in connection with investigations, and where it should be located. In particular:

All records of the investigation that relate directly to the employee will be passed by the DMT Manager to the Senior Employee Relations Officer for storage centrally and separately from the employee's personnel file.

10.48 This allows a bank of information about previous allegations to be available for checking when any subsequent allegation is made.

10.49 These records will be retained for 25 years after the ending of the person's period of employment or until all the children involved achieved the age of 35, whichever is later.

10.50 However, subject to any other legal or practice requirements, the Director of Social Work can decide in individual cases to waive this requirement if he is satisfied that the allegation had in fact no substance.

10.51 The Council's Disciplinary procedure also allows the retention of information about expunged warnings in some circumstances, and further reference to warnings which would normally be disregarded where this is relevant to the safety of young and/or vulnerable people.

10.52 In the course of our enquiries we noted concerns expressed by Unison and BASW Scottish Committee about this matter. Unison fully accepted the right of the employer to retain certain unsubstantiated allegations on an employee's file. However, the Unison representatives speaking at the public hearings drew a distinction between allegations which were "unsubstantiated" and those which were "unfounded" or malicious. In the latter cases, they thought it was not appropriate to retain the information. It appeared they believed they were able to decide which they believed appropriate and which inappropriate.

Recommendation 49: We consider that it is appropriate that the 1997 Children and Families Practice Notes/ Guidelines allows the Director of Social Work to waive the requirements regarding retention of information when he is satisfied that the allegation has no substance, We recommend that a record is maintained of the Director's decision and the basis for it, in a secure, separate location outwith the Social Work Department.

10.53 In all other cases, the current practice of maintaining records of allegations should be continued.

g. Resignation before investigation complete

10.54 We referred above, in connection with Dean House Report 10, to Brian McLennan's resignation shortly before a social work sub-committee considered his status as a "fit person" to have charge of children. During our enquiries we came across a parallel suggestion that employees in Council and voluntary facilities might be encouraged to leave as an alternative to the institution of disciplinary proceedings; or might themselves resign in the knowledge that it was in their longer term interests to do so rather than to have a finding against them kept on file.

10.55 During the public hearings, the Director of Social Work emphatically declared that staff would not be encouraged to leave in these circumstances. However, if an employee resigned, his resignation would be accepted. He could recall only two cases in the previous two years involving situations in which resignations had been accepted before the conclusion of disciplinary proceedings. He accepted that this was a matter which could give rise to concerns and which should perhaps be tackled at national level. He felt there were some safeguards in respect that any reference requested by the former employee would note any outstanding allegations.

10.56 A related concern, referred earlier in this chapter in connection with investigation and staff discipline, is that the 1997 guidelines indicate that, as an alternative to postponing a disciplinary hearing until the conclusion of a criminal trial, the proceedings might go ahead on the basis of "wider concerns" about the employee's behaviour. Our concern is that, if this approach was taken and the subsequent criminal proceedings did not lead to a conviction, there might be no record of acknowledgement of the fact that there were concerns about the risk that member of staff might pose to children.

10.57 These concerns might be allayed with the implementation of the Police Act 1997 provisions with regard to non-conviction information, and also the setting up of General Social Work Council and a Consultancy Index as discussed above in Chapter 9F.

h. Involving the Police

10.58 The Finlayson/Newman Report had recommended (Rec. 21) that the potential of the police to assist investigation process and those involved therein should be recognised and utilised.

10.59 Current child protection procedures place a high premium on involving the police at an early stage of the investigation. We were concerned about one recent case involving an allegation about inappropriate behaviour towards children which was considered serious enough to warrant disciplinary proceedings culminating in dismissal, but which was not investigated. There appear to have been "discussions" about it with the police.

10.60 Our discussion of the case of Child B (Clerwood Report 3) also included a suggestion that some of the ultimately successful investigations At Dean House were under threat for reasons which are not altogether clear, although some of them may have been financial.

Recommendation 50: We believe there should be greater clarity about the grounds for a decision by the police to investigate or not. The reasons for police decisions should be recorded so that future investigations which may be connected can test their significance.

i. Employee's Rights taking over later in the process

10.61 We reflected in Chapter 8 our concern that, when allegations were made against staff, the initial focus on the interest of the child became less obvious as the staff disciplinary process of investigating the allegation gained momentum and became more formal. We also identified as a lesson from the past (Lesson 61) an awareness employers have, often not backed up by detailed knowledge, about the extent of protection afforded to workers by employment law and the difficulties this puts in the way of taking the action that might be considered appropriate to protect children.

10.62 In the course of our enquiries, it was acknowledged that child protection took precedence at the early stages of an investigation. However, there was some concern amongst staff, mostly fuelled by a recent case, that this focus was not carried through the process. This disciplinary case had taken 18 months to conclude. In the course of its consideration, it was the view of some members of staff that the rights of the employee had taken precedence over the rights of the children. They expressed the view that the formality of the disciplinary hearings had been an inhibiting factor, so that the full concerns about the staff member's behaviour towards children had not been put before the disciplinary body.

10.63 Our consideration of this case led us to the belief that there was a need for a greater specialised legal input into the decisions made by the Department concerning disciplinary proceedings. We believe that the principles about the primacy of the child's interest are already set out in the procedures. The Department's fear that failure to comply with all procedural formalities might put the whole case at risk might be alleviated by the ready availability of specialist legal advice.

10.64 We also consider that this issue should be considered by other Council departments whose employees have access to children, and who may not have considered the matter in as principled a way as the Social Work Department have done in their 1997 guidelines.

Recommendation 51: We recommend that the Department put in place a source of legal support for disciplinary matters which is fully conversant with the requirements of employment legislation and child protection and aware of the need to keep child protection as the highest priority.

Recommendation 52: We recommend that the Heads of other Council departments consider how they deal with disciplinary cases involving the safety of children and take advice on formulating procedures to address this.

j. Allegations of historical abuse

10.65 It was of concern to us that there were no real guidelines about this. However we understand that they are currently being produced. This issue is addressed more fully in Chapter 19.

k. Complainers/victims with special needs

10.66 Later, we address the issue of children and young people with special needs. A concern had been expressed to us that allegations raised by them might receive differential treatment because assumptions were made about their ability to give a persuasive account or be reliable witnesses. We acknowledge that this is part of a wider problem. The legal system in general needs to devote its attention to addressing issues about such vulnerable people who may, as a result of their vulnerability be even more at risk of being victims of abusers.

l. Involvement of Child Protection Co-ordinator

10.67 The Finlayson/Newman report recommended (Recs. 24 and 25) involvement of the Child Protection Co-ordinator as an independent check where allegations were made about abuse of a child looked after by the Council. The Co-ordinator would convene a case conference in accordance with the child protection guidelines.

10.68 The Action Plan following the report remitted this recommendation to the Child Protection Advisory Group and the Regional Child Protection Co-ordinator for consideration in the context of updating the guidelines. The Director of Social Work indicated at the public hearings that this recommendation had not been fully implemented. The department's guidance required the Co-ordinator to be advised and to be available for consultancy. A case conference would be called but it would be chaired by the Co-ordinator only in complex cases. Otherwise, the chairmanship of local child protection senior was seen as giving a satisfactory degree of distance.

10.69 More recently, the Kent Report expressed concern that "a child can be abused in a residential unit or foster home without anybody outside the social work department knowing about it." Kent recommended (Rec. 2) that the Child Protection Register be notified of every incident of abuse of a child living away from home; including abuse by peers. He also considered that clusters of local authorities should combine to support Child Protection Committees who would undertake a composite review of any instance of abuse by carers and would facilitate objective investigation by another agency if appropriate.

<p>Recommendation 53: We recommend that the Finlayson/Newman recommendation about involvement of the Child Protection Co-ordinator in consideration of allegations of abuse of looked after children be fully implemented in order to ensure a more independent element in the consideration of the case. This includes allegations relating to children in foster care.</p>

m. Departments other than Social Work

The issues above have been considered against the background of the Social Work Department's guidance and procedures. In the discussion above of SCRO checks, we reflected on the need to take account of these issues also in relation to other departments. Indeed, in the course of our enquiries, significant information came to light about an employee of a department other than the Social Work Department. We informed senior management.

Recommendation 54: We recommend that Heads of Departments other than social work, and specifically the departments of education and recreation, review their own procedures for responding to and investigating allegations in the light of the recommendations of our report.

C. Care and Control Policy

a. Skinner Report

The 1992 Skinner Report made some strong statements about care and control of young people in residential care. It focused on the need for children to feel safe in care and observed that this could not be achieved without setting limits to acceptable behaviour.

Skinner's enquiries disclosed that some children's homes, especially small ones, used no sanctions except staff disapproval. He commented:

Effective control depends upon the effectiveness of disapproval, not on physical restraint. For disapproval to be effective approval must in the first place be important.

Care is thus intrinsically related to effective control.

Skinner commented that training in conflict avoidance and managing violent behaviour were "basic pre-requisites." It was also essential for staff to receive training in setting limits for acceptable behaviour and the use of appropriate sanctions and controls.

b. The Director of Social Work's written submission

10.70 This refers to the Care and Control Policy introduced by Lothian Regional Council in 1991. An extended version was approved by the City of Edinburgh in 1996. The submission states that:

The Care & Control Policy requires to be set in the context of a training programme which allows staff to consider values and attitudes, unit cultures and also methods of intervention which can defuse volatile situations and avoid physical restraint. The Care and Control Policy sets out clearly expectations on staff and the importance of striving to intervene early in a way which can resolve conflicts and not inflame.

10.71 The policy document describes acceptable and unacceptable sanctions and gives guidance on appropriate restraint. It indicates that "Training in physical restraint techniques will become mandatory for all care and teaching staff employed in residential child care units and other designated units in the future."

c. The CALM Approach

10.72 The training referred to above is based on approach called CALM. CALM stands for Crisis Aggression Limitation Management. It includes theoretical aspects involving analysis of issues relating to violence and power, issues about de-escalation, and training in the application of particular techniques for restraint which are designed to ensure that the young person is safely held and that the member of staff is also protected. Once trained, participants have to go through an annual reaccreditation.

10.73 The techniques themselves have been progressively refined. An unfortunate side effect of this is that, within a Unit, there may be staff who have received different versions of

the training. This lessens the benefits of the consistency and mutual understanding which the training is designed to promote.

d. Staff Views on CALM

10.74 The CALM training was a topic which elicited some of the most strongly worded comments from staff. Whilst some appreciated the training in its entirety, the response was overwhelmingly to the effect that the theoretical aspects were good, but the actual practical techniques were not appropriate and not helpful. Some commented that they were based upon a martial arts approach involving difficult techniques and balances. They required too many members of staff to be involved; more than would normally be around to help when a situation blew up.

10.75 Some said the techniques were not appropriate for younger children; others that it was OK for younger kids, but not for older kids who had “lost it.” Some said it was better than nothing; they recognised that staff needed some guidance. Some reported feeling more confident about intervention as a result of the training. Others said it was not always a helpful confidence; it might encourage physical intervention when other approaches would be more helpful.

10.76 There were many comments to the effect that the training was being done to cover the Department’s back. It was seen as being there primarily to protect the Department, rather than to benefit children.

10.77 Some staff said they had expressed their views about the unsuitability of CALM in their written evaluations of the training, but this had evoked no response. We were also advised by a member of staff that a planned evaluation by Stirling University had never materialised.

e. Management’s Views on CALM

10.78 We were very concerned about the lack of confidence staff expressed in the practical application of the training they had received. In the course of the public hearings, the Director of Social Work indicated that, while he did not think that CALM was absolutely right, it was the most appropriate package. Most people would have preferred the ability to “pick and choose” from various packages, but the copyrighting of alternative methods prevented the selection of some of their methods to supplement CALM. A multi-agency group was currently monitoring the effectiveness of CALM.

10.79 The Training and Employee Development Manager acknowledged the need to review and evaluate CALM training; to allow more work at the theory stage and iron out any inconsistencies of approach. Evaluation feedback was currently being sought from staff.

f. Use of Restraint

10.80 Our visits to residential units led us to the belief that there was a wide variation in the extent to which restraint was used. In some units it was a relatively rare occurrence, whilst others reported that it happened every day or two. Some said it came in spates depending

upon the dynamics in a unit at any particular time. If you had a child with particular difficulties, or two residents with a tendency to fight each other, the incidence would increase temporarily.

10.81 Whilst acknowledging that there will be variations for these reasons, we were also aware of the existence of what might be called a “macho” culture in some units, with considerable emphasis placed on the availability of large males to exercise control. One member of staff complained that his own bulk encouraged other staff to involve him in restraint situations, even when he did not really know the child concerned. He felt staff with a relationship with the child would have been able to communicate in a more helpful way during the process.

10.82 A resident in another unit complained that staff laughed while restraining him. This made him angry. There was also a sad comment to the effect that some young people might provoke restraint through a desire for physical contact.

10.83 A student complained that he had been given no training on restraint. He had been told just to call on someone else if a difficult situation arose. However, he felt vulnerable as he was sometimes alone with young people. They knew he was not allowed to restrain and had threatened him to see his reaction.

10.84 It must also be acknowledged that there were staff who believed restraint was not used often enough. In their view, no-one appeared willing or able to control young people. This was seen as an abdication of responsibility.

10.85 The Children’s Rights Officer reported that, over the past few years, young people had been more likely to approach her with concerns that they had been inappropriately restrained, or that inappropriate force had been used. We cannot conclude from the information received that this was a result of the CALM training, but we do believe this adds to the list of concerns about the practical techniques involved.

g. Conclusions

10.86 We were concerned that the CALM training seemed to have such a high degree of priority in the training schedule; more than any other issue. This seemed to us to promote the idea that the job was about controlling young people. There seemed to be more emphasis placed on going on the course than on evaluating whether it worked.

10.87 We appreciate that the matter of care and control is under consideration by a Care and Control Group appointed by the department. We hope they will give serious consideration to the concerns we express and, perhaps more importantly, to those of the staff who have undergone training and who have been trying to give feedback but feel they have not been heard.

Recommendation 55: With regard to the CALM training on care and control, we recommend: (a) an independent evaluation which includes taking account of the experiences of young people and staff who have expressed concerns as to the nature and relevance of that training; (b) that the Inquiry's concerns be transmitted to the Care and Control Group currently convened by the department; and (c) that the Director of Social Work raise at national level the need to devise a training programme for care and control which takes advantage of the best aspects of those training packages currently available.

10.88 We were also concerned at what seemed to us to be a lack of consistency in practice regarding care and control, and the persistence in some units of a culture based upon physical force.

Recommendation 56: We recommend that there be central monitoring of the frequency of restraint with explanations sought for variations amongst Units.

10.89 We recognise any fear on the part of Units of exceeding the average frequency of restraint would be unhelpful if this deterred them from intervening appropriately, and stress that this should not be the case.

D. Recording and Transmitting Concerns

a. The Director of Social Work's written submission

10.90 This states:

Adequate recording in units so that there is a clear record of any incident or concerning event is very important. This recording needs to be accessible to the external manager and the external manager should ensure regular discussion of events recorded with the unit manager. Records should be retained centrally in due course to conform with departmental policies.

b. Lack of consistency

10.91 Our enquiries led us to conclude that there was some variation in the standard of record keeping and the extent to which it was scrutinised by external managers. Those unit staff who said it was not really looked at were quick to point out that they did not say this in criticism of their external managers. Recent cutbacks in staff had meant managers were overwhelmed with work, and this was one of the things that sometimes fell by the wayside.

10.92 There are three methods of communicating important information to senior management, through:

- The incident form
- The violent incident form
- The significant occurrence form.

10.93 There appeared to be some uncertainty about which form should be used in any particular set of circumstances. The incident form addressed matters of lesser significance. Some staff said they would use the violent incident form in some instances of restraint of residents. Others focused it more on violence towards staff.

10.94 The Director of Social Work's written submission indicated that the significant occurrence form was designed to provide a direct line of communication between staff and Directorate. Written procedures set out examples of what might be regarded as significant occurrences. These included outstanding achievements by staff or clients as well as serious accidents (including violent incidents), and the more serious end of the spectrum of illness, absconding, malpractice, etc.

10.95 During the public hearings, the Head of ELRIS (Edinburgh and Lothians Inspection and Registration Service) indicated that he had also found some inconsistencies in the recording of incidents and significant occurrences, both within and between units. He felt this might be improved by:

- simplified reporting formats;
- simplified reporting routes;
- training; and
- feedback from and to staff and children.

c. Views of Staff

10.96 There were also differing views amongst staff about the relevance and effectiveness of the modes of the forms.

10.97 Some described the significant occurrence form as a "waste of space"; just another form to be filled in. They said that, no matter what you put in it, it came back with a tick against the box saying "Keep me informed." Some gave examples of cases where they had seen submission of the form as a "scream for help", but none had come. One manager said: "Nine times out of ten the events recorded on the form are about someone who is extremely violent and abusive of other residents."

10.98 Whilst staff who gave this kind of response viewed the Directorate's response as indicating a lack of interest or support, others seemed to accept that the purpose of the form was to keep the Directorate informed and were not disappointed about the response because they did not expect anything else. If there were more general issues about the appropriateness of placements or the welfare of residents, they said, they should be addressed in other ways; through care plans, for example.

10.99 With regard to the violent incident form, one staff member described the response when staff had been subjected to violence as "late and patronising." Again there were suggestions that the procedure was more about the department "covering its back" than about concern for staff.

d. Appropriate use of forms

10.100 From the Directorate's point of view, the purpose of the different forms may seem clear. However, it may not be so to all staff. If they have unrealistic expectations, they will feel let down if the response they hoped for does not materialise.

10.101 It is concerning that there appear to be units in crisis, largely through what staff consider to be inappropriate placements which put residents and staff at risk. Some staff use the significant occurrence form as a way of drawing management's attention to that crisis.

10.102 On a more minor matter, we consider that there may be a point in dealing in a different way with the more positive achievements so that they receive an appropriate response. Otherwise there is a danger that they will get lost amidst more negative matters that take priority.

10.103 One qualification to the whole issue about recording is that one of the young people we spoke to told us that the worst thing about being in residential care was that everything got written down. It is important to ensure that there is a real purpose to recording and that it is not experienced by young people as intrusive and oppressive.

e. Independent organisations

10.104 Independent organisations providing residential services do not have a similar hierarchy of notification procedures. Some do have a system for recording incidents. The Head of ELRIS suggested a need for a protocol for independent units so that the Council could be satisfied that relevant incidents were recorded and transmitted to governing bodies as well as being available to inspectors.

f. Conclusions

Recommendation 57: We recommend that the purpose of the incident, violent incident and significant occurrence forms be clarified, and rationalised if appropriate. There should be an identifiable purpose for recording of incidents involving young people in order to avoid any unnecessary intrusion on their privacy.

Recommendation 58: We recommend that a space on the significant occurrence form should allow staff to indicate whether they regard the issue as one requiring an immediate response. They should be required to justify this claim. Where such a space has been used, an immediate response should be given.

Recommendation 59: We recommend that the Head of ELRIS enter into negotiations with independent facilities providing residential care for the city's children to devise a protocol for reporting significant incidents.

Recommendation 60: We recommend that the Director of Social Work consider devising a separate procedure for communicating positive achievements within residential units.

E. Retrieving Absconders

a. Motives for Absconding

10.105 The Skinner Report referred to the observation of the 1991 Scottish Office Absconding Working Party that "in some circumstances the child's absconding is an attempt at self-preservation and in these circumstances therefore has not to be condemned." Skinner recommended (Rec. 43) that local authority managers and inspection units should routinely gather information on absconding rates from residential homes and schools, and investigate

patterns, causes and solutions based on the recommendations of the Absconding Working Party.

10.106 There are indications that the instinct for self preservation was a motive for absconding in relation to some of the victims of the abuse leading to this Inquiry.

b. The Director of Social Work's written submission

10.107 This indicated that a protocol on responses to absconding had been completed with the police and would shortly be reported to the Social Work Committee. Later information indicated that it was implemented on 12 October, 1998. It was therefore not in operation at the time of our visits to the units. Our observations are therefore based on the procedures operative up until that date.

c. Views of Staff

10.108 None of the residential care staff we spoke to thought absconding was a particularly serious problem. They distinguished proper absconding from what was a much more regular occurrence; failure to return at the agreed time.

10.109 We came across some differences in practice with regard to the time at which the police were contacted (generally midnight or 1am) and the processes for transmitting information about the young person to the police. We do not detail these as they will have been superseded by new procedures.

10.110 When the young person returned, the police talked to them, followed by staff. Sometimes there was a relevant issue. One unit's talk with a returning abscondee disclosed that he had run away because he was afraid of another resident. However, in general, we did not get the impression that seeking the reason for the young person's action was something that was taken very seriously. Some workers assumed that they knew the reason and told us that young people generally ran away because they felt they should be allowed out later, or they wanted to visit a boyfriend/girlfriend. This may be true in a large number of cases. However we believe that staff should be truly open to the possibility that there is another reason which it would be appropriate for them to know. Young people must feel that the talk engaged in on their return is a sincere attempt to identify any problems rather than something that has to be done as part of a procedure.

d. Views of Young People

10.111 One young person who had stayed away overnight told us that he had done so because he wanted to stay with a friend. He resented the need for an SCRO check (discussed in Chapter 9E), which he found embarrassing; so he had just left without permission.

10.112 Another group of young people gave us their perspective on the response to absconding:

Police call at your pals' houses. When you get back, police interview you and tell you not to do it again. They ask you what you were doing, and you tell them a pack of lies. The police then usually tell staff to ground you. You get a "discussion" with your key worker and you are told not to do it again.

10.113 The young people thought the police were called in too early; even if they were only an hour late. Some of them thought there should be a 24 hour gap before the police were involved.

e. The 1998 Protocol

10.114 The new protocol applies to establishments under the control of the social work departments of Edinburgh and the three Lothian authorities. It does not apply to independent units. It acknowledges that reporting processes for staff and carers when a young person goes missing have been in place for several years. It recognises the fact that similar lengths of absence will give rise to different levels of concern because of factors peculiar to particular young people.

10.115 A process of discernment of risk is to be followed by identification of the appropriate level of response classified as Red, Amber or Green, in decreasing order of concern. The assessment of risk is to be reviewed during the progress of any particular incident of absconding; and each incident is to be the subject of a fresh assessment even if the young person is a frequent absconder.

10.116 Police Liaison Officers will be attached to Young People's Centres. Staff will have standard forms on which to record details of the young person and a recent photograph if one is available. These should be faxed where possible. Another form is to be used when the young person is found. Information and statistics are to be shared on a regular basis.

10.117 When a young person is found, he or she is not to be held in police custody unless there are exceptional reasons for doing so. The protocol adds:

All staff must be particularly sensitive to situations where a young person is expressing serious concern and distress at being asked to return to the carer or unit from where they have absconded. On rare occasions this could signal that they have experienced abuse in placement. A careful exploration of the reasons for the refusal/reluctance to return should be made externally to the unit or carer.

10.118 The last sentence of this quotation needs to be fleshed out. Who should undertake this external exploration? Should it happen at the discretion of staff? Should it be put to young people that they may wish to discuss the reasons for running away with the Children's Rights Officer or other independent person?

10.119 There is a reference in the protocol to the sharing of information and statistics. It also provides that:

The external manager of the unit should review the pattern of absences from the unit with the Unit manager no less than quarterly to assess the need for any action to reduce the numbers missing or any training staff may need in dealing with the incidents.

10.120 A manager told us:

I remain concerned that some possible indications of problems are not always viewed in a sympathetic light. Children are still running away from care placements and do periodically make allegations about staff/carers. There should be a central/senior management overview on all of these allegations.

10.121 We believe it is important that statistics are kept on the frequency of absconding with regard to particular young people or particular units. In this connection, full use should be made of the experience of the Emergency Social Work Services Team in responding to absconding. The information should be forwarded to the Registration and Inspection Unit (see Chapter 11 below) for analysis and consideration.

f. Conclusions

10.122 There is much to commend this protocol. It seems to address some of the issues on inconsistency and lack of flexibility raised by those we spoke to. However we do retain some concerns, therefore:

Recommendation 61: Whilst we acknowledge that the recently introduced protocol on responses to absconding calls for a careful exploration of reasons for any reluctance to return, and also for a review of patterns of absences from the unit, we recommend that staff and field workers should endeavour to analyse every incident of absconding and the reasons therefor, and pay particular heed to any patterns emerging from repeated absconding with regard to individual young people.

Recommendation 62: The wording of the protocol on absconding should be amended to clarify matters relating to the involvement of an external person to talk to an absconder. It would be appropriate for all such young people to be offered the opportunity to speak to the Children's Rights Officer, Who Cares? or another independent person.

Recommendation 63: Statistics on absconding, relating both to the young person and the unit should be forwarded to the Registration and Inspection Unit for analysis. The experience of the Emergency Social Work Services Team in this connection should be taken into account.

Recommendation 64: The protocol on absconding should be extended to independent units.

F. Dealing with Difficulties - Main Themes

10.123 The theme running through this section on “dealing with difficulties” is a concern by staff that the departmental response has more to do with protecting itself from criticism than with protecting children or supporting staff.

10.124 For example, the 1997 Child and Families Practice Notes/Guidelines set out a range of responses to allegations of abuse by employees or carers. The staff perception is that these are not fully utilised and that suspension is automatic. The view of some staff was that, at this point of the process, the child protection issues are given an exaggerated profile in order to protect the department from criticism, even though this may not always be justified by the circumstances and the known facts.

10.125 We have also discussed the concern that this balance changed as the disciplinary process proceeded, so that the rights of the employee came progressively to the fore.

10.126 Taking account of these expressions of concern, we have formed the view that a lack of confidence in the ability to exercise judgement seems to result in the focus lurching from the child to the employee. It would be more helpful were there to be a more principled and balanced approach throughout the process. This does not mean that the paramountcy of the child's interest should be downgraded, but that there should be more discrimination at the early stages about what pursuit of this principle implies; and greater tenacity in upholding this principle in the later stages of any disciplinary processes.

10.127 The Department's concern to cover itself was also identified by many staff as the motivation behind the CALM training, the processes for recording and transmitting concerns and the requirements to carry out SCRO checks on the friends of looked after young people before they can stay overnight with them.

10.128 The dilemma for the Inquiry is that, in order to move from this defensive position, the Department needs an injection of confidence in its own ability to do the right thing. It needs encouragement rather than criticism from us. It needs the support of specialised and informed legal advice. It would benefit from the support of a professional body such as a General Social Work Council which could act as independent guardian of good standards.

10.129 The Department has done a lot of valuable and thoughtful work in the production, for example, of the 1997 guidelines. We would encourage the department to implement them in a thoughtful and confident way.

11. KEEPING WATCH

A. Introduction

11.1 We have distinguished “keeping watch” from “identifying and expressing concerns” within this report. Under “keeping watch” we have looked at the inspection process, visits by management, and visits by Council members. None of these can be relied upon to pick up individual instances of abuse. That is not their purpose.

11.2 The inspection process has a role in ensuring that systems and standards are such as to minimise the possibility of abuse. Visits by management perform many roles, including keeping an eye on how the systems are operating. The main benefit of visits by elected members is likely to be the impact on informed decision-making rather than in monitoring safety.

B. Inspection

a. The Director of Social Work’s written submission

11.3 This referred to the *Residential Care Services Review 1991* which provided for the appointment of inspectors to extend inspection to residential child care units.

b. Scope of Inspection

11.4 The Edinburgh and Lothians Registration and Inspection Service (ELRIS) covers all four Lothian authorities. The Head of ELRIS reports through Edinburgh’s Director of Social Work to a Joint Committee of Edinburgh and the Lothian authorities. Two officers specialise in child care and are dedicated to working with the 34 residential units.

11.5 Foster care is not currently subject to this inspection, although foster carers themselves are subject to a careful selection process. The Kent Report recommended that foster care should also be brought within the inspection process. This matter is considered below in Chapter 13.

11.6 Two formal inspections are carried out per year for each unit, with reports made available to district and headquarters managers. An Action Plan must be produced by the Unit Manager and Service Provision Manager setting out how and when areas identified as requiring attention will be addressed.

c. Independent Establishments

11.7 Independent establishments are not only inspected by ELRIS, but have to be registered by them and can be deregistered if they do not meet the required standards. Local authority establishments are not subject to registration or de-registration.

11.8 ELRIS plays a greater role in supporting independent establishments than it does with regard to those run by the local authority. Some of this relates to matters such as advice on procedures and help with investigation of complaints, in relation to which the Social Work Department has its own expertise.

11.9 ELRIS also has a monitoring role with regard to independent establishments. For example, the independent services provide information on child protection issues arising out of a child's placement, investigation and/or disciplinary action against staff, serious instances of absconding, formal complaints about health and safety, etc. The Head of ELRIS indicated that discussions were ongoing with the four Lothian authorities about extending this flow of information to include local authority establishments.

d. Independence of Inspection Process

11.10 Inspection is a delicate task. However, we found that there was widespread appreciation of the role of ELRIS. Most units reported that inspection was thorough and helpful and that the relationship with the inspectors was very good. In some units, the inspectors came to know the young people by name.

11.11 Some staff acknowledged that there was also a disadvantage in this familiarity, in respect that the process became less "inspectorial." This was a factor which inhibited past staff at Dean House from confiding in the Assistant Principal Officer who was at that time holding what has been described as an "embryonic" inspection post with regard to voluntary organisations (see Dean House report 10 in Chapter 4).

11.12 One of our interviewees suggested that there should be two inspectors; one of whom provided the continuity, with the other keeping a bit of distance. Some staff thought that an "arms length" inspection unit was not independent enough. It should be completely independent.

11.13 The Head of ELRIS acknowledged that there was a difficult balance to be achieved between getting to know the staff in the units and being so close as to be suspected of collusion. This dilemma was recognised to a certain extent in respect that staff workloads were periodically changed.

11.14 Later in this report (in Chapter 16) we consider the whole issue of independent scrutiny of residential units and independent support for particular children. In that context, we recommend the introduction of Appointed Visitors modelled on the provisions of the Children Act 1989, on the understanding that these operate more as an extension of the inspection process than as a source of independent support for individual children.

11.15 We also consider that young people with experience of the care system have a valuable contribution to make to the inspection process. Indeed, some of the victims of past abuse expressed strongly to us their view that only such people could have a real insight into the dynamics within a unit.

11.16 Based upon their experience, they said there was a need for greater inspection of children's homes, with more frequent and unannounced visits. Inspectors needed to be clear about what they were looking for. They needed training in recognising the subtler signs of abuse. One past victim claimed to be able to identify an abused child through the "mask" he or she would be presenting to the world. Another said her own experiences had developed her ability to "sense fear" in a unit.

11.17 Whilst many of the past victims acknowledged that there were personal issues to be worked out before they themselves could make this kind of contribution to safeguarding young people currently looked after by the Council, they did feel strongly that those with experience of the care system had a unique and important contribution to make.

11.18 We are aware that the Who Cares? organisation is involved in assisting with inspections in some areas by visiting with inspectors and by meeting with young people as residents' groups and helping the group to feed their views into the inspection process.

Recommendation 65: We recommend that the Head of ELRIS continue discussion with Who Cares? Scotland to identify the most appropriate way of introducing into the inspection process the perspective of those with experience of the care system.

e. Contribution to Safeguarding Children

11.19 What contribution does and can inspection make to safeguarding children? Kent commented (Para 8.6):

It is not the job of an inspector to go into a unit in order to find abuse, but rather to look at the standards, the quality and type of care that are provided and whether safeguards are in place that would make abuse less likely to happen.

11.20 This insight was confirmed by some of the staff we spoke to. It would be unrealistic to expect an inspection to pick up instances of abuse. It might happen in some cases where the young person had developed a trust in the inspectors, but inspection is only a part of the network of measures to detect abuse.

11.21 Nevertheless, it may be important to record that the Head of ELRIS stated, in the course of the public hearing, that last year's inspections had disclosed absolutely no concerns about physical ill treatment or inappropriate physical contact. Nor had inspections brought out any evidence to suggest that children in smaller, independent establishments were at any greater risk than those in larger units. The reports generally indicated that staff were well motivated, and relationships with young people were positive.

11.22 One of the concerns expressed by ELRIS was that it had less power with respect to local authority facilities than it had in relation to independent establishments. As indicated above, local authority establishments do not require to be registered, and therefore cannot be de-registered. He indicated that the standards of one local authority unit were so low that it would have been de-registered had it been in the independent sector. This is a national issue relating to the legislation for such establishments. It was the subject of comment by the Kent Report which recommended (Rec. 27):

Registration, and therefore the possibility of de-registration, should be required for Local Authorities' own units.

11.23 In our view, if an establishment falls so far below acceptable standards that an equivalent independent establishment would be closed down, it should not be allowed to remain open merely because it is run by a local authority.

Recommendation 66: We recommend that the Council exact the same standards of their own residential resources as they expect of independent establishments in respect of registration and de-registration, and accept the same implications if an establishment is assessed as falling below those standards.

Recommendation 67: We recommend that ELRIS be identified as a focal point for the collection and analysis of information relating to local authority units in the same way as currently happens with independent units, with regard to child protection issues, investigations and disciplinary actions, serious incidents of absconding, and formal complaints about health and safety issues.

11.24 As reflected above, inspection is only part of the network of measures to detect abuse. It is important to ensure that there is efficient communication with all other parts of the network and that there is a central point of available collated information. ELRIS maintains regular contact with the Children's Rights Officer, the Complaints Officer and with Who Cares? Scotland, through meetings involving various combinations of participants. Whilst there may be advantage in this to address specific issues, we recommend that:

Recommendation 68: Regular four-way meetings between ELRIS, the Children's Rights Officer, the Complaints Officer and Who Cares? Scotland should be developed for the purpose of sharing insights and information, identifying needs for further information, and facilitating an informed approach to policy development with regard to safeguarding children.

C. Visits by Management

11.25 The Director of Social Work's written submission states:

“ Service Provision Managers are required to visit all their residential units regularly. In addition to regular visits they will have extensive phone contact and contact at a range of meetings that Unit managers will be attending.

The external manager of a residential unit – the Service Provision Manager (Children and Families) – is a key person in picking up on regular visits any oppressive or inappropriate behaviour which could lead to distress for the young people. He/she will examine incident registers and staff are required to complete a significant occurrence form if there are certain incidents which place young people at risk or staff at risk. This is then followed up by the Director or Head of Operations to ascertain the outcome of the occurrence.

11.26 It also referred to the Kent Report's recommendation (No. 49) that

The need for time to be set aside by senior figures to visit establishments must be recognised by employers.

11.27 The Director said that he fully agreed with this recommendation, which related to the Directorate, and himself in particular. However work pressures and the management of “huge budget cuts” since reorganisation had meant that the frequency of such visits had been reduced. He commented: “This position is unhelpful and unhealthy as far as organisational or service development is concerned.”

11.28 Staff indicated to us that Service Provision Managers do visit, but that the frequency of visits and the time they can spend has been adversely affected by staff cuts and the sheer weight of responsibilities they now bear. Some made a point of speaking to children and were

well known to them, at least by name. In other units, children did not know the identity of the unit manager's "boss." As indicated above at Chapter 10D, there appear to be some inconsistencies in the extent to which they consult the incident registers.

11.29 We appreciate the difficulties faced by the Directorate in visiting establishments and the commitment to make such visits a reality. We make no specific recommendation in that regard. We also recognise the difficulties faced by Service Provision Managers in the face of increased responsibilities. However, it is also important to remember from the past that one of the factors acting against children telling about the abuse they suffered was that they had no real idea that the unit manager had a "boss." Whilst it would be unhelpful to undermine staff authority within a unit, children and young people also have to know that everybody is accountable to somebody, and that no-one has absolute authority over their lives. We therefore do not offer this as a personal criticism, but we recommend that:

Recommendation 69: The Director of Social Work should ensure that Service Provision Managers have sufficient time clearly allocated for visiting units to carry out their monitoring and supportive role. Other senior Directorate staff should recognise the value to be gained from their individual visits.

D. Visits by Council Members

11.30 The Director of Social Work's written submission indicated that elected members' visits to Units were currently undertaken on an *ad hoc* basis. The 1991 Review had proposed a scheme for regular visits. This was not pursued for a number of reasons. Principally, members were concerned at the time commitment involved in making this effective and meaningful.

11.31 There was a muted approval from our consultees for the suggestion of regular visits by elected members. Some staff commented that it might give elected members a more realistic view of what could and could not be achieved. There was also some indication that young people welcomed the opportunity to meet those ultimately in charge of resources.

11.32 We discuss in Chapter 17 the lack of clarity with regard to the expectations of elected members serving on outside bodies. We believe there can be value in members visiting so long as the purpose is clearly defined. It may be that it is more a case of inducting members into this important responsibility rather than seeing it as an additional safeguard. Elected members need to be clear about their responsibilities for providing high quality care. Visits by elected members might help put budget cuts and lack of resources into context.

Recommendation 70: Elected members should consider how best to inform themselves of issues related to life in residential units for which they have responsibility. This could include meetings with young people and the possibility of visits to units. The Children's Rights Officer should be available to help discuss how this might be achieved.

11.33 Young people are also entitled to the same access to their elected representatives as other citizens.

Recommendation 71: We recommend that information about elected members and how to contact them should be made available to children and young people who are looked after by the Council. Staff should help them make appropriate contact.

E. Keeping Watch - Main Themes

11.34 Our main concern is the lack of consistency of standards across residential units which is facilitated by the fact that local authority facilities do not have to comply with the same standards and processes as independent units. We believe there would be benefit in the Council's voluntary submission to the standards required of independent units, and a strengthening of the independence of ELRIS to allow it to perform a more clearly independent monitoring and enforcement role.

12. IDENTIFYING AND EXPRESSING CONCERNS

A. Introduction

12.1 Whilst the processes discussed above designed to “keep watch” are a necessary part of any system, it is also necessary to recall Lessons 5 and 20 from the past which were that, to the outside world, Glenallan and Dean House appeared to be happy and successful units. Both were visited regularly by community policemen, and Dean House in particular was open to the visits of a succession of concerned volunteers from the neighbourhood. There is a need to ensure that particular concerns are not camouflaged by a general appearance of contentment.

12.2 The Council clearly has an obligation to set up structures to facilitate the identification and expression of concerns about the safety of the children looked after by it. This chapter of the report looks at the roles of key workers within residential units, social workers visiting them, education staff, befrienders, the Children’s Rights Officer and the Who Cares? organisation. It also evaluates the impact on safety of processes such as reviews, children’s hearings and complaints procedures, and suggested innovations such as exit interviews.

B. Social Workers and Key Workers

a. The Director of Social Work’s written submission

12.3 This stated:

Every child looked after by the City of Edinburgh Council should have their own social worker based in a children and families practice team and a child placed in residential care should have a key worker i.e. a member of the unit staff who has particular responsibility for that child.

12.4 A Quality Standards document regulates the frequency with which a social worker should visit a child in residential care. This builds upon legal requirements set out in the appropriate regulations. During the course of our enquiries, issues were raised both about the allocation of social workers and the frequency of contact with them.

12.5 These matters had previously been addressed by the Finlayson/Newman Report which concluded (Rec. 13):

We recommend that the District Managers make a priority of ensuring allocation of cases where young people are in residence; that fieldworkers as part of their responsibilities make it clear to young people who are about to be placed in care or those who are in care that they are available and would wish to hear about any issues of concern that may arise for the young person as a result of their being in care; that fieldworkers recognise that up till now in many instances (despite their protestations about “good relationships”) that they have not provided an effective outlet for such matters and should use that recognition to work out how best they can provide for that contingency in the future.

b. Allocation of Social Workers

12.6 During the public hearings, the Director of Social Work said that, while the principle of this recommendation by Finlayson/Newman had been accepted, implementation

had been partial. Difficulties with staffing levels, as a result of the operation of a performance factor on the department's staffing budget, sometimes resulted in non-allocation for a period. During this time there would be general oversight of the case by a senior.

12.7 The Planning, Purchasing and Commissioning Manager (Children and Families) indicated that there were currently 10 young people in foster care with no allocated social worker. In each case, urgent steps were being taken to address the matter. There were at that time no children in residential units without an allocated social worker. However, we met one young person with no *available* social work contact during our visits to units. She told us that her social worker was on long term sick leave. She said wouldn't know who to contact if she had a problem. She felt she should have been allocated another social worker while her own was absent.

Recommendation 72: In line with Recommendation 40, we recommend to the Council that the critical importance of the safety of children requires that any application of the performance factor to field social work should recognise the importance of time spent by them in discharging their duties to children in residential and foster care.

Recommendation 73: The Director of Social Work should ensure that children and young people are made aware of who to contact if their field social worker is unavailable. In cases of long term absence, another social worker should be allocated.

c. The Nature and Frequency of Contact with Social Workers

12.8 The nature and frequency of contact seemed to be very variable and to depend upon the individual social worker. One of the lessons from the past (Lesson 28) was that the demands on field social workers did not allow them to give children in residential care as much time as they needed. We indicated that, in our view, young people needed their social workers more than ever on being admitted to residential care. These visits need to be given high priority by social workers.

Recommendation 74: We recommend that social workers be required to give the same priority to meetings with young people in residential or foster care as they do to departmental meetings or child care reviews.

12.9 With regard to frequency, there were some examples of good practice. On the instruction of the Head of Operations, residents of secure units receive one visit per week. The manager of an independent establishment which received children from many local authorities told us that, in his experience, the visiting rate of the Edinburgh social workers was very good. One in particular was exceptional in both frequency and quality of contact. The foster parents we contacted spoke positively about the regularity of visiting by field social workers.

12.10 The nature of the contact raises other concerns. To what extent are visits by social workers a real safeguard? The Planning, Purchasing and Commissioning Manager (Children and Families) indicated at the public hearing that, although field workers routinely sought views from children in care, there were no automatic structures to ensure detailed feedback to them on the child's safety. We noted with regard to the past that the children who

had been abused reported that they had not experienced their contact with social workers as a safeguard (Lesson 17).

12.11 One young person currently in a residential unit told us that she would not tell her social worker if she had a concern. Although the same person had been her social worker for one and a half years, she had never really spoken to her about things other than her clothing allowance, and wanting to go home. Her view of the worker was that her heart was in the right place, but “If you tell her something she will sit for the whole day and go “Well, well” and then you won’t hear anything for a month or two.” This echoes the experiences reported by Finlayson/Newman which led them to identify this kind of worker as “nice but ineffectual.”

12.12 It is more difficult to monitor and regulate the effectiveness of visiting social workers than the frequency of their visits. However, unless they are purposeful, there is not much point in advocating an increase in regularity. Part of the purpose should be to inform children immediately on admission to the unit that they should tell their parents or field social workers if they ever have any concerns about what is happening in the unit or about their own safety, “such as having been bullied by other residents.” Such a phrase need not necessarily raise inappropriately fears that other forms of intrusion into their safety may arise. As the placement develops the field worker should continue to assess the child’s safety with a recognition that in the past some children have been the victims of abuse while in care.

12.13 In our view, it should be emphasised to social workers that they do have an important role as the “external eyes” in relation to the child’s placement, and that they should be aware of this in their interactions with young people. It would also be helpful to set out what would be regarded as a normal frequency. Residential workers seemed to think that once a fortnight would be acceptable. During the public hearings, the Department’s representatives expressed the view that most social workers did in fact visit the children fortnightly.

Recommendation 75: We recommend that the frequency of visits by social workers to children in residential or foster care be monitored. This should form part of the information collated for analysis by ELRIS and shared with the Children’s Rights Officer. Patterns and changes of patterns of visiting should be identified for the purposes of resource management and policy development, and to help identify any particular child who was not receiving appropriate external support and those who might benefit from a visit by the Children’s Rights Officer.

d. The Key Worker’s Role

12.14 If the allocated social worker is seen as the department’s “external eyes” in relation to any particular child, the key worker is seen to hold the main responsibility within the unit for matters relating to the child.

12.15 The Director of Social Work’s written submission says:

The young person's key worker will strive to work closely with the young person to create a relationship of mutual trust within which problems and concerns can be shared. If a member of staff, for example the key worker, is unhappy about how a young person is cared for within a unit, there is an expectation that they will tell either their line manager, the child's social worker, another senior manager or a member of staff from Employee Relations. The recently introduced Policy on Free Expressions of Staff Concerns underlines and hopefully facilitates this.

12.16 In general the key worker system was valued by residents and staff, although the actual role seems to have developed in a slightly different direction from that described above. This was a result of a recognition by staff that the person allocated to the child as key worker might not turn out to be the one who develops a relationship of mutual trust with the child. Some staff expressed concern that too much emphasis on this aspect of the key worker's role could lead to "preciousness" about the relationship. This would be unhelpful if it inhibited a child from forming a relationship with another member of staff whom he or she did trust, and to whom the child might be more likely to express any concerns. Some staff groups said they addressed this by making it clear to everyone that it was appropriate and permissible for any child to approach any member of staff.

12.17 This meant that the key worker's role was largely to do with co-ordinating the information relating to a particular child, writing reports and attending reviews and children's hearings, etc. One staff member said:

It's useful to have someone who knows everything. It avoids kids "playing the game" and leads to better advocacy. We would have real concerns about changing the system. It could lead to staff manipulation. No-one would have responsibility to find out the real truth.

12.18 The manager of another unit commented:

We try not to focus on one key worker. It is bad for staff who can be held responsible for the child's behaviour. The Key Worker's role is liaison and care plan, not exclusive responsibility for the young person. Some young people get precious about their key worker.

12.19 One unit had developed a system where two key workers shared key responsibility for a child. This was particularly helpful when a staff member was on leave or absent on training or through illness. In another unit there was a move towards doing away with the key worker system. The manager explained:

The key worker system can put too much pressure on one member of staff and one kid. What tends to happen is that staff direct the kid to the key worker. We are trying to develop team responsibility within each unit. The child should be able to choose who to do business with; not just one person.

12.20 Staff in that unit had varying views about this. Some indicated that they did not think there was preciousness about the key worker's role. It was pointed out that it helped parents too to have a named person with specific responsibility for their child.

12.21 It seems to us that, although phrased in different ways, there is a large amount of agreement amongst staff about the advantages and potential disadvantages of the key worker system. It is necessary to have someone with specific responsibility for the purpose of co-ordinating information and external liaison. We have learned from the past (Lesson 15) that it

is not helpful to have the key roles concentrated in the unit manager. However, it cannot be assumed that the person identified by the department for this role will be able to “create a relationship of mutual trust” with the young person. The young person does not have the right to choose or change their key worker. This of course raises the question whether they should be able to do so.

12.22 Some thought there could be difficulties in introducing choice. One manager warned that “Some young people are good at splitting and manipulating.”

12.23 It seems to us that staff are more or less united in their view that there is benefit in the key worker system insofar as it is necessary to have a nominated person who acts as the unit co-ordinator for the child. This is a useful function, but it is not a safeguard in respect that it is acknowledged that a child would be more likely to express concerns to a trusted individual of their own choice than to someone allocated to perform that function. It would be unhelpful in terms of safeguarding the child were there to be an expectation that the child express concerns only through the key worker. Therefore, if the expectation is retained that the key worker develop a particular relationship of mutual trust, the child should be able to choose the key worker. The alternative is that it is acknowledged that the key worker’s role is mainly about co-ordination of information, with a special responsibility for picking up concerns. This would be carried out more through being aware of and addressing situations in which it appeared that the child had not formed a trusting relationship with anyone, than necessarily being that trusting relationship him or herself. It may subsequently become clear in some cases that it would be better for the key worker role to be reallocated so that the roles were combined in one person. Therefore,

<p>Recommendation 76: We recommend that the key worker system be retained, but that there be official acknowledgement that one cannot rely on the person exercising this role acting effectively as the internal safeguard for the child. The key worker’s role should be seen as largely a co-ordinating one, with a specific responsibility for ensuring that the child or young person has a suitable confidante.</p>

e. Division of Roles between Field Social Workers and Residential Staff

12.24 The Skinner Report had recommended (Rec. 57) that qualified key workers should be able to hold full case responsibility within agency review systems, when this was in the best interests of the young person or child. When this was done, care should be taken to ensure that young people and children continued to have regular contact with other professional adults.

12.25 During the public hearings, the Director of Social Work indicated that the Department had resisted this recommendation. In their view, the involvement of the social worker provided an “external eye” and therefore added to the protection of residents.

12.26 Our exploration of the issue set out above resulted in a recommendation that the role of the social worker as the external eye needed to be clarified and emphasised. However, we will return to this issue later in the report in connection with the issue of independent visitors.

12.27 The Skinner recommendation deserves closer consideration for other reasons. Skinner had observed:

In most homes there is considerable scope for further development of the role of key workers. Key workers may play a part before, during and after a young person or child is admitted to residential care and could develop their role in relation to families.

12.28 A senior social work manager expressed to us his view that the professionalism of residential staff and their ability to help the young people in their care was undermined by a lack of detailed knowledge of the resident's history. He suggested that, when a child or young person was admitted to a unit, the allocated key worker should, within a short time of admission, examine the totality of the child's case with the field social worker and make a presentation to unit staff based on the information gained.

12.29 He had introduced this practice within one unit on an experimental basis. In the case of one resident, this had brought to light information about intrafamilial abuse earlier in the child's life. Had this procedure not been followed, it may well have been the case that those with responsibility for looking after the child would not have known that significant piece of information. To an outsider it might seem strange that this could be the case. However it can happen, for example, that when a prolonged attempt to support a child within the community breaks down, the report to the children's hearing leading to admission into residential care concentrates on the recent events and difficulties precipitating the need for admission rather than past history.

12.30 A more comprehensive knowledge of the child's background, combined with the experience of daily care of the child, puts the residential worker into a stronger position with regard to contributing to decisions about the child's future.

12.31 A residential worker told us:

Our opinion isn't rated on review reports and the like. We can go through mayhem with kids, but a field worker who meets them for half an hour in McDonalds is listened to.

12.32 We believe that, even if key workers are not given full case responsibility, there is a strong case for integrating them more into the decision-making processes with regard to a child. The status and significance of the key worker's role will be enhanced, and the welfare of residents promoted, by setting in place procedures which will ensure that residential staff are in possession of all relevant information in relation to a child. In our view, this would enable staff to carry out a better job of caring for residents and thus make residential care a safer place for residents.

Recommendation 77: We recommend that departmental guidance be amended to provide that, within 48 hours of admission of a child or young person into residential care, the key worker, or some other member of staff delegated by the Unit manager, examine the totality of the child's case with the field worker with a view to making an early presentation to unit staff on the child's history and the significant care issues raised by it.

C. The “Whistle-Blowing” Policy

12.33 Guidance was issued by the Department in February, 1998, entitled “Free Expressions of Staff Concerns about the Safety and Well-Being of Service Users.” Its aim was to help staff raise concerns when they believed that the behaviour of a colleague towards a user of the service had caused or was likely to cause the user harm.

12.34 It is difficult for staff to raise concerns about colleagues. We noted from the past that staff in Dean House attempted to do so with little success (Lesson 23). Glenallan staff also tried in various ways to indicate that all was not well within the unit (Lessons 11 and 46). What was also significant was that the concerns staff wished to pursue were about bad management rather than suspicions of abuse. In our view, bad management may provide a setting and a culture in which abuse is more likely to take place. It is appropriate that “whistle-blowing” procedures should apply not only to considerations about safety, but to concerns about bad management practices which jeopardise the general welfare of residents and may be conducive to the development of abusive situations. The current policy document does make general reference to concerns about “professional issues” and may well be broad enough to cover those concerns not known to be related to abusive situations. However we believe that this wider application should be made clearer. With the development of a more professionally trained staff, staff should feel more confident and qualified to raise these more general concerns with the expectation that they will be listened to.

Recommendation 78: We recommend that the “Whistle Blowing” policy be amended to encourage staff also to raise concerns about bad management or other practices which could jeopardise the welfare of residents.

12.35 The guidance says that the member of staff’s first approach should be to his or her line manager, unless it is that person who is the object of the concern. In this case, the employee should approach the next tier of management. The guidance promises that “Under no circumstances will employees be penalised for expressing their concerns.”

12.36 This is a reassuring statement. However, BASW Scottish Committee told us that, despite employers’ commitment to whistle blowing (they were not talking specifically about Edinburgh), it was their experience that individuals might find themselves subject to victimisation. These types of situation form a significant proportion of the cases dealt with by the Association’s Advice and Representation Service.

12.37 We also received a communication from a member of staff who said she had been “cold-shouldered” by other staff members in connection with her reporting of a concern. The incident itself is under investigation by the department. Whether justified or not, the staff member’s concern about the impact of “whistle blowing” exemplifies how difficult it is to ensure that actual human experience matches the expectation of written policies. It underlines the importance of putting in place an independent route for expression of concerns, and also support for the person “blowing the whistle.”

12.38 We should also take into account the content of the anonymous letter discussed in Chapter 5, in which the authors stated that “Employees feel that they are still unable to speak

out about past and present abuse in residential units as the abusers are seen to be protected and even rewarded.”

12.39 Most of the staff who spoke to the Inquiry said that, the “whistle blowing” policy apart, the culture had changed anyway and that they would feel confident about expressing concerns about a colleague. A manager commented:

20 years ago people didn’t even have the vocabulary to discuss these things. Now they do.

12.40 However some staff did express the opinion that they would like to have an identified person outwith their normal line management structure whom they could contact about concerns.

12.41 We found no evidence that senior management were deliberately covering up allegations or “rewarding” abusers. However, we do understand the very real and human concerns that staff can have when considering whether to give information about a colleague or when, having summoned up the courage to do so, they feel that management’s response is not appropriate. In our view, it would be helpful if a Children’s Commissioner or Child Welfare Commission were to be established at national level with a broad remit, including acting as recipient of concerns about the safety of looked after children. The idea of appointing a national children’s ombudsman, possibly reporting to the Edinburgh parliament had also been suggested during the public hearings by the Convener of the Social Work Committee. As an alternative, he had suggested that Edinburgh might pilot a local service through the Children’s Rights Officer.

12.42 Our own experience as an ad hoc body is that people have been willing to express such concerns to us. However, we have not been equipped to respond to them all, and to have attempted to do so would have unacceptably extended the period of our appointment and thus delayed our report. Accordingly, we make recommendations aimed at introducing a more independent element within the Council as a whole. It would be outwith the power of the Council to set up a national body, however we do believe that the experience of this Inquiry should encourage them to reflect on the wisdom of pursuing that idea in the national policy forum. Whilst the idea of a local Edinburgh ombudsman is also attractive, we feel that, at this time, there is more to be gained in terms of safeguarding children looked after by the City of Edinburgh by extending the Children’s Rights Office in the ways suggested later in this report. This is due partly to the fact that, unless the ombudsman was accountable to someone other than the Council, the same issues about independence would inevitably arise.

<p>Recommendation 79: The Council should consider raising at national level the need for a Children’s Commissioner or Child Welfare Commission with a Scotland-wide remit.</p>

12.43 We suspect that it is easier to feel confident about expressing concerns if you have never been in the position of having to do it. One manager observed that many of his staff seemed to think that it had nothing to do with them. However, a unit that had recently been confronted with it (before the policy was introduced) had a different perspective. What disturbed staff there was that individually many of them had had feelings about the behaviour of the worker concerned, but couldn’t articulate them. Since the matter had come into the

open, staff had talked a lot about it and had been horrified at the picture that had emerged when they put all the pieces together.

12.44 The guidance says: “Employees should attempt to be as specific and detailed in the provision of information relating to their concerns as possible.” The dilemma for staff is, how specific do you have to be? This seemed to be an issue for some of those with concerns about Locums, as discussed above, who preferred not to commit them to writing.

12.45 It is very difficult to address these issues in a staff circular. Staff need the space to confront their own feelings and reach a situation in which they will feel more confident about their own judgement, and about the kind of reaction they can or should be able to expect from managers.

12.46 We referred at Chapter 8C to a video training aid produced by Barnardo’s entitled “Sounding the Alarm.” This took a particular case through from the point of suspicion, doubt and reporting, towards both appropriate and inappropriate responses from the line manager. We were very impressed by this video and we believe that it, or something like it, would provide a valuable supplement to the written policy, and should be used for training in whole staff groups. While it would undoubtedly have benefit in an induction course or any course where staff from different units attended, the maximum relevance would be obtained by staff who worked together viewing it together. The video runs for under 30 minutes. Showing it at a staff meeting would provide a highly relevant focus for discussion and clarification of the departmental policy document. Staff who felt concerned about colleagues’ work practice in regard to children’s personal safety ought to be more able in such a context to express these concerns. The Scottish Director of Barnardo’s has indicated his willingness to make the publication available to the department for this purpose.

12.47 Whilst some of the independent establishments we visited either had their own policy or were working on one, we were concerned that the operational structure of some establishments would make whistle blowing difficult. We encountered some situations in which the owners of independent establishments were also the employers of care staff. Whilst we had no reason to suspect anything was being covered up, those in charge recognised that staff might fear they would find their jobs at risk if they criticised their employers. This seemed to us to present a real potential for concern.

Recommendation 80: We recommend that the Department supplement its written policy on whistle-blowing with use of Barnardo’s “Sounding the Alarm” video, or something similar to it, and that this should be shown and discussed in whole staff groups.

Recommendation 81: We recommend that the Free Expressions of Concern (whistle-blowing) policy be amended to include an identified individual outwith social work line management to whom staff have the option of taking concerns. Consideration should be given to ELRIS (Edinburgh and Lothians Inspection and Registration Service) taking on this role.

Recommendation 82: We recommend that support independent of line management is provided for any staff member raising a concern about a colleague.

Recommendation 83: We recommend special vigilance with regard to safety issues when a child is placed in an establishment where the owner has operational responsibilities for child care.

D. Reviews

12.48 The Director of Social Work's written submission refers to the legal requirement for regular reviews of a child's case as an additional safeguard. The young person is encouraged to write a report and attend the review. The submission adds that a young person can ask to see the Chairperson privately if he or she were worried about expressing a view in an open meeting. However we did not come across any reported instance of that happening.

12.49 There was a mixed response to the question of reviews. Young people do not like attending meetings where there are lots of people talking about them. Neither do they like not being there, so that they feel people are talking about them behind their backs.

12.50 One of the victims of past abuse had explained to the Inquiry what it felt like to be a child attending a meeting where people were talking about you:

It's like being a plant in the centre of a table, and people are sitting around it and talking about the plant.

12.51 Clearly, there will be individual differences in the extent to which young people regard reviews, which are a necessary part of the system, as opportunities to explain concerns.

E. Children's Hearings

a. The Director of Social Work's written submission

12.52 This indicated that some young people looked after by the Council were subject to supervision requirements imposed by a children's hearing. The Director found this to be particularly the case for children in local authority units. Supervision requirements had to be reviewed at least annually, although there were opportunities for a number of people, including young people and parents, to call for earlier reviews. This constituted an additional safeguard by presenting a further opportunity for the identification or expression of concerns.

b. Speaking Out at Hearings

12.53 Mixed views were expressed by staff and young people about the extent to which children felt able to speak out at hearings. Again, this is probably related to a number of factors, including the confidence of individual children, both in themselves and in the system to take effective action to make things better for them.

12.54 Some staff thought children saw attendance as a burden. And indeed, members of the Inquiry were party to some interesting discussions amongst groups of young people who compared experiences of, and strategies for, dealing with hearings. In one such group, there seemed to be an implicit understanding that the main aim of the strategy was to get the process over with as quickly as possible. One young person explained that her experience was that the less you said, the sooner it was over. Another disagreed. He found it easier to say

something quickly rather than have panel members spending a long time encouraging him to talk. They had no difficulty in talking amongst themselves in our presence.

12.55 Other inhibitors included the presence of those very people about whom the young person would have wanted to express concerns. One young person said she had experienced problems with her foster placement but could not tell the panel because her foster carer was present at the hearing. Another made similar comments about the presence of her mother.

12.56 For children in residential placements, the fact that they may be accompanied by a key worker or other member of staff could be equally inhibiting. A feature of some of the cases of abuse leading to the setting up of this Inquiry was that children who were attending hearings were accompanied to them by the abuser (Lesson 15).

12.57 We were particularly concerned about the arrangements in a privately run residential establishment outwith the city where the practice was for the child to be accompanied by the person who both owned and managed the establishment. Although we have no reason to believe that there is anything to hide, it seemed to us that this arrangement was inappropriate and could be inhibiting for the young person. The young people in that establishment reported that they found children's hearings OK, but they would never dream of saying anything at them. In that respect, their views echoed that of many other young people who spoke to us.

12.58 We referred earlier in this report to a situation in which a child in residential care in the past had made an allegation against McLennan which had been investigated by the police, but which was never reported to the children's hearing. We consider that it is important for the hearing to know about all allegations, even if subsequently withdrawn, or if determined to be without foundation. If a child is making allegations then something is wrong with the child's relationships. Telling the hearing reinforces their role as external check with regard to the child's safety and allows them to explore with the child relevant issues about the placement.

12.59 In our view, children's hearings can provide an important independent check on the young person's safety and welfare. However, that is dependent upon them receiving accurate information about how the young people are experiencing their placements. Whilst some young people are confident enough to make their own views known, many need extra help. Few at present are accompanied to the hearing by a person of their choice. If they were so supported, the potential for hearings to act as an independent check would be enhanced. The person might be a friend of their own age rather than an adult. Children's hearings should recognise the possible inhibiting effect of the presence of the child's current carers. New legal powers, introduced by the Children (Scotland) Act 1995, allow hearings to exclude parents and their representatives in order to hear the child. We believe they should also be prepared to ask accompanying staff or foster carers to leave to allow them to talk to the child. If this became a routine practice, it would not be experienced by the adult as indicative of a suspicion.

12.60 We explored some of these issues with representatives of the children's hearing system in the course of the public hearings.

12.61 The Chair of Edinburgh Children's Panel said that panel members were trained to be open and approachable. Young people had the opportunity to speak either personally or through an independent advocate.

12.62 However, she accepted that the hearing situation was not ideal for encouraging disclosure of abuse. It was an artificial setting and a young person experiencing abuse within their placement might well associate the abuser with the panel who were responsible for the placement. She did not feel it would be realistic, or even helpful, for panel members to ask automatically about potential abuse, but did accept that there might be merit in panel members considering asking staff and carers to leave to give the child a short period alone with the panel and the Reporter. This was not current practice.

12.63 She indicated that young people also had the option of communicating with the panel in writing. However, written submissions were not common and rarely included significant information. The extent of this safeguard had been reduced relatively recently with the introduction of a requirement to share all reports with parents, including those written by their children. This was the result of regulations introduced following a case in the European Court of Human Rights. It was an inhibiting factor for children. Occasionally the Children's Reporter had had to advise children to consider adjusting reports before they were circulated. The Reporter Manager indicated that he was hopeful that forthcoming legislative changes would help protect the young people's disclosures.

c. Continuity of Membership

12.64 There were indications from some young people that they found it helpful and reassuring to have some continuity in panel membership at hearings. One described the difficulty in talking to the panel because there were always new faces. One said that, on the three or four occasions he had attended, the same person had always "been in the middle." He liked her because he knew her from earlier panels. Another said she felt she could have told the panel about any difficulties because "the same guy was always there," and he made her feel good about herself. Yet another said that he recognised the Chairman of his hearing "knew the score," and believed that, if he was really concerned about problems in the unit, he could have told that Chairman.

12.65 The Chair of the Children's Panel accepted during the public hearings that it would be good practice to have greater continuity. It was very difficult to organise rotas to accommodate it, although attempts were made for some hearings. The recent introduction of a power for hearings to set a date for a review had led to some panel members asking to be present at the next hearing.

12.66 The Authority Reporter observed that a change in the work culture since the 1980s had had an adverse impact on availability of panel members to attend particular hearings to provide continuity of membership.

12.67 Accordingly, we recommend that:

Recommendation 84: Increased efforts should be made to inform young people that they can invite a representative of *their* choice to the children's hearing, and to encourage them to do so.

Recommendation 85: Children's panel members should consider creating opportunities to speak to children outwith the presence of their carers. Their training should include awareness of past incidents of abuse while children were in residential or foster care and the difficulties these children have experienced in telling of such incidents.

Recommendation 86: Continuing consideration should be given to attempts to obtain a degree of continuity of panel membership at review hearings.

Recommendation 87: Where any child who is the subject of a supervision requirement has made allegations of abuse of any kind during their time in residential or foster care, the fact that that allegation has been made, even if subsequently withdrawn or found by the department to be without foundation, should be included in the review information which is provided for the panel members at the next children's hearing.

F. Exit Interviews

12.68 The Kent Report recommended that:

All young people should be interviewed as they leave services by way of an exit interview. (Recommendation 55)

12.69 The rationale for this was that they would feel safer to comment on the care they had received because they would not fear reprisals.

12.70 Those we spoke to agreed that valuable information could come from young people who had left the system. However, we share with many a concern that a formal exit interview would have a limited impact. At the point of leaving care a significant number of young people are not well disposed to those who have cared for them or the very system that looked after them and might be unlikely to be open and objective and forthcoming. This reluctance would be especially likely for any child who had been the victim of abuse. The experiences of the past have taught us that those who have been abused tell their stories slowly and only when they themselves feel ready to do so. Abuse in particular is a very private hurt that young people are unlikely to disclose in a one-off formal interview.

12.71 Why after all should they tell? It involves exposing what many have experienced as a hurtful humiliation. It is likely to involve them in contact with the police and with systems which will test and interrogate them. There is no guarantee that they will be believed.

12.72 The young adults who were the victims of abuse by Knott and McLennan identified a variety of motives for telling later in life. Some would never have told had they not been approached by the police, and had the police not gone at their pace, as many were quick to tell us. Before that, some had not even told their loved ones. They were encouraged to come forward because they knew others were also doing so, therefore there was a greater chance of their being believed and something resulting from it. Others had tried to tell in various ways over the years, because they wanted to be believed, they wanted justice and they wanted help. And yet others had come forward out of concern for their own children and the next

generation of children in care. Many told us that exposing their own private pain would have been worth it if it helped stop it happening to other kids.

12.73 In our view, young people will disclose more readily in the context of an on-going relationship with the department through a supportive aftercare package than through a formal exit interview. This does not mean that exit interviews do not have value. It might well be helpful for young people and the department if care-leavers were to be encouraged to reflect on their experiences. However, in addition to all that has been said over the years about the necessity for good aftercare and continuing contact because they are necessary in themselves, we would add that ongoing relationships of this kind are more likely to help young people come to terms with their own past vulnerability and enable those who have been hurt to tell about what happened to them.

12.74 This is currently happening on an ad hoc basis. One unit manager told us of a young person who had lived in the unit from age 12 to 17. However, it was only when she was 20, and still in contact with the staff, that she felt able to tell them about abuse she had suffered outwith the unit as a child. One past victim from Dean House raised the issue of her own abuse in care with a former staff member then working for a voluntary agency when she became a resident in a facility run by that agency.

12.75 Is the current level of aftercare likely to facilitate such disclosures? We asked about aftercare during our visits to units. Many Units did encourage ongoing contact and young people did take the offer up. During one of our visits, a birthday party was in progress for an ex-resident. The unit had provided a cake and a present. It was good to see such a genuine and generous attempt at making a care-leaver feel welcome and cared for.

12.76 Other units were less confident in their ability to provide the kind of ongoing support young people needed. Not all young people took up the support that was on offer.

12.77 We were particularly concerned with the situation regarding residential schools. Staff at the local authority school indicated that a lot of young people did come back to visit, although the aftercare package in itself was almost non-existent. However, all of the residents had, during their stay at the school, a home base elsewhere. For some that was a Young People's Centre. The situation was different with regard to independent establishments. One such residential school had some children resident with no alternative home base (although our understanding is that none of the Edinburgh residents at that time was in that situation). The school indicated that it had no formal role or funding relating to aftercare.

12.78 We believe that it is important that a young person who has spent a significant time in any residential establishment should be encouraged and facilitated to keep in touch with those with whom they have formed trusting relationships.

12.79 During the public hearings, the Planning, Purchasing and Commissioning Manager (Children and Families) confirmed that the department's through-care and aftercare policies did allow for support to care leavers. Nevertheless, she agreed that a more structured dialogue between the young person and the department would be valuable.

12.80 It should also be noted that a significant number of young people who have been in care do have further contact with the department. Court practitioners readily recognise that many former residents commit offences which are prosecuted in court. In many such instances the court will call for a social enquiry report and such reports will frequently lead to a probation order being made. Social enquiry reports will be prepared, and probation services provided by, social workers in criminal justice teams. Many young people have more confidence in criminal justice social workers than in child and family teams, and see themselves as having more to gain from good relationships with them. We learned that three past victims of abuse made reports to social workers in criminal justice teams. One such report was made to a social worker preparing a report for the court; one to a probation officer operating a probation order; and one to a worker who was managing a Supervised Attendance Order. In the first case the department failed to take matters forward. In the second, the importance was recognised but not followed through. In the third case the issue is being appropriately addressed.

12.81 It is important that criminal justice workers are receptive to any reports made by their clients and do not assume that they are merely attempts to divert attention from their offending behaviour. In particular, attention should be paid to Lesson 39 from the past in respect that a reluctance to report to the police should not be interpreted as an indication that what the former resident is saying is untrue. There may be other reasons for a reluctance to enter into an association with the police.

Recommendation 88: We adopt the Kent recommendation number 55, concerning exit interviews, to the extent that it would be helpful for staff and the Social Work Department to have the benefit of the young person's reflection on their period in care. However, we consider that this should be the start of an ongoing process. We recommend that the Department develop a supportive aftercare package and the opportunity to continue with trusted relationships, not just because they represent an appropriate discharge of responsibilities, but because this kind of approach is more likely to help young people tell about any abusive experiences.

Recommendation 89: Independent units should not be exempted from providing an element of through care to help young people move on. We recommend that that this be clearly discussed and identified in the planning process and that funding arrangements take account of this requirement which should form part of the contractual agreement between the Council and the independent unit.

Recommendation 90: Further to Recommendation 8 above, we recommend that all social workers, but particularly those in criminal justice teams, be trained and supported to help them understand how the experience of life in residential or foster care can have a lasting impact on young people. In particular, they need to be aware of the possibility that such experiences have not been positive; to be receptive to hearing and taking seriously reports about this; and to be clear about their responsibilities in taking further action on the reports where appropriate.

12.82 Reflecting back upon Lesson 46 from the past, we see merit in introducing exit interviews for staff as well as residents.

Recommendation 91: Residential care staff who resign, except for obvious reasons such as moving away from the area or for promotion, should be interviewed by external managers to ascertain the reasons for their resignation. In particular, any unusual patterns of staff resignations should be closely considered. Such interviews would provide an admirable opportunity for external managers to be advised of any concerns that staff members have in relation to general care and safety issues for residents. Such interviews would also provide a basis for responding to subsequent enquiries which may be made of external managers to provide references for future employment which may well impact on the safety of other children.

12.83 Reflecting back upon Lesson 53 from the past, we consider that consideration requires to be given to the appropriate use of probation, supervised attendance and community service orders in relation to 16 to 18 year olds, in respect that breach can currently lead prematurely to custodial sentences.

Recommendation 92: The Director of Social Work should raise with his professional association, COSLA and the Social Work Services Group whether it might be possible to revise National Standards for social workers in criminal justice teams with specific reference to appropriate amendment in relation to young offenders between 16 and 18, or possibly to age 21.

G. Support through the Education System

12.84 The Director of Social Work's written submission identified the educational provision for looked after children as an additional safeguard. It was the Council's policy to maintain continuity of education as far as possible. The child would therefore often be returning to their home school where they would already have established relationships with teachers. A Code of Practice on the Education of Accommodated Children set out principles and procedures designed to support this. It said that every school should have a named member of staff whose role it would be to liaise with residential unit staff and foster carers regarding issues affecting the child.

12.85 Both past victims and young people currently looked after shared with us their own views about the extent to which they would be able to express concerns to school staff.

12.86 In one of the past cases of abuse, a teacher whom the victim trusted personally had guessed something was wrong and had been quite persistent in questioning him about it. The young person had resisted because he did not know what would happen as a result, and feared that the information would get back to the abuser at the unit. Another past victim told us that there was a teacher she would have told at a previous school, because that person knew her and would have been more likely to believe her. However she did not feel able to tell anyone in the schools she attended after going into care. Some young people related to us incidents in which they had expressed concerns to teachers with some success. A child in foster care was very clear that she trusted her guidance teacher so much that she would tell her if anything was wrong, and had in fact done so in the past. Lesson 66 from the past in particular highlights the need for those involved in education to be trained in identifying and responding to concerns about the safety of children.

12.87 From the perspective of being an additional safeguard, the important factors are:

- the trusting relationships the child might have formed with individual teachers (or indeed with other school staff) who might have no formal role in liaison or even in guidance;
- the ability of such teachers to take matters forward in a helpful way once the child has disclosed their concern; and
- the fact that the whole edifice is built on the assumption that children do in fact attend school, which is not always the case.

12.88 We therefore propose to look at three issues:

- attendance at school;
- continuity of education; and
- what happens once a child tells.

a. Attendance at school

12.89 During the public hearings, the Education Department's representatives indicated that 9 children in residential or foster care were currently excluded from school. Whilst we cannot dispute that low figure, it came as something of a surprise to us. In one of the units we visited, three residents were described by the young people as having been "fired out." In another unit, two residents had no current placement and the unit manager was devoting much time to trying to obtain places. We came across a few others, and we hardly touched foster care. We wondered whether there were less formal exclusions not included in these figures. However, we have nothing but our own speculations to substantiate this.

12.90 We are aware that there is sometimes an unwritten understanding that some young people who present particular difficulties are "not expected to attend," and no real attempt is made follow up their non-attendance.

12.91 It may be that our perception that a good number of young people were not attending school was based on the inclusion of those who refused to attend rather than having been excluded. School refusal is a further source of concern, as it lessens the availability of school as an additional safeguard.

b. Continuity of Education

12.92 During the public hearings, the Education Department's representatives confirmed their commitment to continuity of education and to the education of the child at their home school wherever possible. As commented on in Chapter 8 in connection with corporate responsibility, we found encouraging examples of this commitment being put into practice. The department were looking at ways of making day schools better able to manage wider needs. In particular, they were trying to reduce out of city placements as far as was consistent with the welfare of children; given that there were a few children whose needs were so special that a specialist resource was required for them. They had managed to reduce out of area placements considerably over the previous two years. It was noted that an average out of authority placement cost £45,000. If this sum was kept within the authority, it could pay for a teacher and a care worker.

12.93 Reference was made during the public hearings to "Working Together" a joint initiative of social work and education, replacing the earlier "Youth Strategy." This was the

source of a number of jointly funded and jointly managed projects. There was a commitment to working jointly in pursuit of common objectives. The barriers to achieving this were financial rather than structural.

12.94 There were said to be particularly difficult issues affecting those children who also had specific health needs. There were still some unresolved questions about how this would be managed after the current restructuring of health services.

Recommendation 93: We recommend that the Council continues to develop and increase joint initiatives aimed at keeping more children within their local schools.

Recommendation 94: We recommend that the Director of Social Work should collate the following information with a view to its being reported on an annual basis to the Social Work and Education Committees: (a) the number of children who have no school allocated; (b) the number who persistently refuse to attend; (c) the number “not expected to attend” because of an informal understanding; and (d) the number of children who are excluded.

c. What happens once a child tells?

12.95 During the course of the public hearings, representatives of the Education Department said that staff hearing of allegations of abuse would automatically follow the Child Protection Guidelines which were available in all schools, although members of staff did not necessarily have an individual copy. All key staff received 1-2 days in-service training on the Guidelines. Many then offered all-school training to their colleagues. As a supplement, a range of in-service training was available on specific issues. There was a clear expectation that all staff would know the reporting arrangements when abuse was suspected. Even if the member of staff approached by a child was not clear what to do, he or she would know who to go to in the school to find out.

12.96 It seems to us important that staff are aware, not just of who to contact, but what will happen after that. If they do not know this, they may be less confident in receiving the confidences of young people and less able to advise them about what will happen. For example, if the teacher referred to in Chapter 3 in connection with Child G’s experiences at Glenallan, who showed a commendable degree of concern and persistence in asking him whether something was wrong, had been aware of the possibility that the child’s problem was rooted in what was happening in the unit, and had been able to give him a clear explanation of the processes that would follow on from him telling anything about the Unit, there might have been an earlier disclosure. This is dependent both upon the processes being appropriate and the teacher knowing about them.

Recommendation 95: We recommend that all schools take advantage of the whole school training on child protection, and that there be an annual refresher course for all education staff as part of in-service training. We also recommend that significant non-teaching staff such as auxiliaries and janitors be included in the training.

H. External links through Activities and Befrienders

12.97 The Director of Social Work’s written submission identified involvement in external activities as another safeguard for looked after children, in respect that it widened the

circle of friends and adults and thus the scope for a child to express distress. The submission also acknowledged the need to ensure that the activities themselves did not provide opportunities for abuse.

12.98 The Skinner Report had recognised the general benefits to young people of involvement in recreational activities, although it had not identified this as a safeguard against abuse. It recommended (Rec.26) that recreational budgets should always be sufficient to provide structured week-end and holiday activities, and also (Rec. 58) that budgetary responsibility should be delegated to residential care staff.

Staff of some of the units we visited were able to list activities in which some young people were involved. However, involvement in external activities did not appear to be a regular feature in the lives of the young people, or one which was actively encouraged. In fact, there were some indications that young people in care dropped external activities in which they were previously involved. One residential worker explained his view:

Kids in care lack confidence in social interaction, unless it's something next door or a block away or you take them there by the hand. Their interest is in pool, snooker, games machines. They want everything brought in. There is often not enough staff to take young people out. The activities form is also a bureaucratic barrier. It would be better if you could just account for it at the end of the year. It would make you feel trusted. The form needs to be simpler.

12.99 This was echoed by staff at another unit:

Young people seem to drop external activities; sometimes because there are not enough staff to take them.

12.100 More positively, one of the units we visited was close to a youth facility which was frequently visited by the residents and about which they were very enthusiastic. They said it was a good laugh. They had, for example, helped organise an Easter weekend. They felt they would be able to tell the workers there if they had a problem at the unit. This happy arrangement was helped by the fact that the location of the facility and the ages of the residents meant that they could attend unaccompanied and did not need transport.

12.101 Staff at another unit expressed the view that it was helpful to have befrienders who could provide outside support for young people and accompany them to external activities. As well as resolving some of the practical problems in linking young people with the activities, this could help counteract the stigma they felt about being in care. Befrienders were welcomed especially by younger children who liked the regular contact and the possibility of being taken out or getting additional treats.

12.102 We believe that more could be done by the Council as a corporate entity to encourage children looked after by them to take advantage of available leisure and youth facilities. Some of these will be run by the Council itself.

<p><u>Recommendation 96:</u> We recommend that the Director of Social Work enter into discussion with the Department of Recreation to identify ways in which the Council's corporate commitment to looked after young people could be expressed through increased access to leisure facilities.</p>

Recommendation 97: We recommend that the Director of Social Work consider whether the procedures surrounding involvement in external activities are too bureaucratic and whether they could be simplified.

12.103 We believe it is important to develop more befriender programmes. We will consider this issue again later in the context of other suggestions about advocates and independent visitors.

I. Client Services and Complaints

12.104 The Director of Social Work's written submission indicated that the Department operated a complaints procedure which accorded with legal requirements. In addition, since 1991 the Department had employed a Client Services and Complaints Officer. The Officer reports to the Business and Communications Manager, although much work is undertaken directly with the Director. The Complaints Officer maintains a database of information received, and advises appropriate colleagues, including the Children's Rights Officer and the Registration and Inspection Unit, of complaints made. The procedure is specific about the action to be taken when a complaint discloses a suggestion of abuse or malpractice.

12.105 There are statutory provisions about timescales for responding. The complaint has to be acknowledged within 5 days. A response has to be made within 28 days, although this can be extended by agreement. If the complainer considers the response unsatisfactory, it can be referred to the Complaints Review Committee.

a. Information about the Service

12.106 The Finlayson/Newman Report had recommended (Recs, 29 and 30) that information about complaints procedures be made available to young people in care and their parents. During the public hearings, the Director of Social Work indicated that these recommendations had been implemented. His written submission explained that a complaints leaflet specially dedicated to children was updated in 1996 and circulated along with the more general leaflet. It had a freepost card attached to facilitate contact.

12.107 The Department's Complaints Procedure says (page 7, paragraph 7) that "Departmental residential units will display prominently and issue to all new residents the department's leaflet to service users on the Complaints procedure." The Complaints Officer said there was a need to constantly monitor the availability of complaints forms, to ensure that they were not locked away. She was reasonably confident that they were now freely available, although there was always room for improvement.

12.108 We found some inconsistencies with regard to availability of the forms during our visits. In most of the Units the young people knew how to get a form and anticipated no difficulties in accessing them. In one Unit, the residents said that when they asked for a form, the staff would say they didn't have any; although the young people knew that there were some in the cupboard. In another unit, the Manager explained that he did not give young people direct access to the forms. He preferred to deal with the matter inter-personally first. He did not want to foster a "complaints culture." In yet another Unit, information was available, but it was the adult version rather than the one designed for children. Some units

adopted a practice at the initial meeting after the child's admission to the unit of informing them of the complaints procedure as part of their introduction. Others did not. Some children maintained that the subject of complaints had never been raised with them.

12.109 The Skinner Report had recommended (Rec. 17) that all children and young people in residential care should be able to make a confidential complaint without the knowledge of the staff of the home. However it seemed that in most of the Units, this was not possible as residents had to ask for a complaints form.

12.110 During the public hearings, concerns were explored about the appropriateness of the form for younger children, and also for those in foster care, who tended to be younger and more isolated. It was suggested that this was a problem nationally. It had been the subject of discussion with Who Cares? Scotland. Moreover our limited contact with foster carers disclosed that two out of three of the carers did not know about the complaints procedure.

12.111 Children with special needs might also need extra help to inform them about the process and help them to identify and take forward complaints. During our visits to units, we met a resident with learning difficulties which affected her ability to read. Staff had indicated to us that information about the complaints procedure was displayed on the wall, but the resident, unsurprisingly, knew nothing about it.

12.112 At the conclusion of her contribution to the public hearings, the Complaints Officer set out her own priorities for improving the system. These included more work with foster children and their carers, and better links with children with special needs. We agree with these priorities.

12.113 We also found some staff who said they did not understand the complaints procedure. One worker was not sure whether it was for complaints from staff or from residents. There was also some confusion amongst staff about how the roles of the Complaints Officer and the Children's Rights Officer related to each other.

12.114 Merely giving a complaints form to a person with a problem can seem to be a very unsatisfactory and clinical response. The written information accompanying complaints forms should encourage young people to talk to staff about the matter first; but it should be made clear that they do not have to do this. If staff are aware that a young person is considering making a complaint and the young person is not willing to engage with staff to resolve it, any reluctance to engage should not be pursued inappropriately. There should be no barrier put in the way of a young person making a complaint.

Recommendation 98: We recommend, with regard to complaints procedures that: (a) consistency be sought in ensuring that complaints forms are accessible without the need for asking staff; (b) residents and their parents should be given clear explanations of the existence of the complaints procedure and how to use it as part of their introduction to the Unit; (c) special consideration should be given to younger children and those with special needs, and, as far as possible, age-appropriate written information should be available for them; and (d) the department should ensure that all foster carers and foster children know how to use the complaints procedure.

12.115 Staff need to be clearer about the complaints system, both for their own sakes, and so that they can communicate it to children and parents.

Recommendation 99: We recommend that staff be trained in the use of complaints procedures and their own role in supporting young people to use the system properly.

b. Contacting the Complaints Officer

12.116 During the public hearings, The Complaints Officer described the processes surrounding the making of complaints by looked after young people. Complaints could reach her in a variety of ways. Young people could write using the Freepost system, phone, or make an appointment to see her. Sometimes they just turned up. She would discuss the matter with the young person and explore with them whether they needed any additional support. This could be from the Children's Rights Officer, another member of staff, or someone outwith the Department. She would arrange this for them. The complaint would be acknowledged by a personal letter from the Director.

12.117 The Complaints Officer accepted that some young people would prefer not to put their complaints in writing. They did sometimes telephone, but there could be problems related to the need for privacy in making and receiving phone calls about complaints.

12.118 During our visits to Units, we had paid special attention to the availability of facilities for making private telephone calls. Skinner had recommended (Recommendation 9) that "Young people and children should be able to make and receive telephone calls in private." However, we discovered that facilities for this were very limited. Generally, the phone was in the office. Sometimes staff would allow the young person privacy, but this often seemed to be left to member of staff's own judgement. Staff expressed fears, based on experience, that residents would use phones indiscriminately for endless chats with friends, or inappropriate number calls to chatlines, etc.

12.119 Some units had payphones located in corridors, which again were not private. Some had had more private payphones but had discontinued them either because they were being broken into, or because of under-use. Sometimes the availability of a cordless phone allowed a measure of privacy when talking to family, but this was at staff's discretion. In other units, children were allowed privacy to phone their parents or social workers, but staff would dial the number and might enquire as to the reason for the call.

12.120 In one Unit where there appeared to be a high degree of distrust between staff and residents, young people did have the possibility of making private phone calls from a separate room, but they feared that their calls were being recorded.

12.121 It is of course true that, with the exception of some children in secure accommodation, children would be free to use public call boxes, such as en route to school. It could be argued that that facility provided a higher degree of privacy for them.

12.122 We can understand that there might be justification for monitoring and limiting the availability of inappropriate calls in some cases, especially where there are restrictions on contact between the young person and specified others. These restrictions should be limited to

safety grounds and should be explained to the young people. We do believe it is important that young people have facilities for private, direct telephone contact to express concerns.

Recommendation 100: We adopt Skinner's recommendation number 9 about the need for young people to be able to make and receive private telephone calls. This can be achieved in a variety of ways, through the use of phone cards, for public call boxes or phones appropriately sited within the unit, and the use of cordless phones. All Units need to adopt the good practice that is already happening in some Units. We recommend that the Director of Social Work audit the situation within units and take appropriate action where units do not comply with the Skinner recommendation.

c. Process

12.123 When a complaint was received, the Complaints Officer would make a recommendation to the Director about a person to be appointed as investigating officer. She would advise on timescales, monitor the investigation, get a full report and make recommendations about the response.

12.124 All responses to complaints are sent to the Director personally for approval and signature.

d. Feedback to Complainant

12.125 The Kent Report recommended (Rec. 4) that a child making a serious complaint should be supported and should be informed of the outcome of their complaint by the person who investigated it. This had also been the subject of recommendation by Finlayson/Newman (Rec. 23) to the extent that the young person should be kept informed of what was happening and of the eventual outcome.

12.126 The Complaints Officer indicated that the response to the young person could be transmitted in a number of ways. It was always given in writing, but she was conscious that a letter might not be user-friendly. The response might also be given through the supporter, who would explain it to them. There had been one complaint made by a young person about a lack of response; this had been entirely valid and had been taken seriously.

12.127 Some residential staff thought there was a lack of clarity about who had the responsibility to respond to young people and notify them of the outcome of a complaint. Some also said that they themselves received no feedback about complaints made within their Units.

12.128 During the public hearings, the Complaints Officer set out her own priorities for improving the system. These included more proactive work in seeking the views of young people about the complaints process, and consistency in feedback, possibly through an independent person. It was also acknowledged that satisfaction levels could be monitored. We agree with this approach.

12.129 Issues about response to complaints which had also led to other investigations are considered in Chapter 10.

Recommendation 101: We recommend that satisfaction levels about feedback on complaints be monitored and that the department seek to ensure more consistency in feedback, possibly through an independent person.

Recommendation 102: We recognise that some complaints should remain private to the young person, but we recommend the department give further thought to ensuring that, where appropriate, relevant information about the outcome of a complaint is passed to the unit manager.

e. Withdrawn Complaints

12.130 Sometimes a young person might decide not to pursue a complaint after filling in a form and handing it to staff or after it has been sent off. When this happens, some units told us that they kept a record of the withdrawn complaint, both as an added safeguard, and in case the young person wanted to reactivate it. In other units, staff thought there needed to be a clearer understanding about what to do in these situations.

12.131 Experience from the past (Lesson 34) shows how young people can be persuaded to withdraw complaints or allegations by explicit or implicit pressure. Our concern is mainly with allegations, which may or may not surface as complaints. However, even with complaints that do not involve particular allegations, a consistent pattern of complaining and withdrawing may indicate a general unhappiness that ought to be enquired about. We believe that the safety of children and young people is better safeguarded by keeping a record of withdrawn complaints. These should be scrutinised by the external manager who will have to apply his or her own judgement in deciding whether to take the matter further.

Recommendation 103: We recommend that complaints procedures make it clear that withdrawn complaints should be kept on record in the unit for scrutiny by external managers.

f. How the Complaints System is Used

12.132 During the public hearings, the Complaints Officer indicated that, out of the 305 complaints received in 1997/98, 38 had been made by children or young people in residential or foster care. Three related to ill-treatment by staff. Eleven were complaints alleging physical or emotional abuse by other residents. None related to sexual abuse. The pattern had not changed over the past five years.

12.133 Some staff thought young people used the system for “silly issues.” They might ask for complaints forms, but “nine times out of ten” would not fill them in. This promoted a power imbalance between residents and staff. It could make a worker feel very vulnerable.

12.134 Some young people also referred to using the procedure as a way of “letting off steam.” One said she regularly made complaints when she was feeling annoyed. She got letters back saying it was being dealt with. She didn’t really expect any reply.

12.135 It is important to remember some of the voices from the past when assessing residents’ patterns of complaining. One victim of past abuse gave us a very clear explanation of how she would test the system out with something like the need for new trainers. If the person came up with a result, she might continue to test credibility by trying something else.

Another said that adults should be aware that what might seem trivial to them might be significant for the young people:

Small things can be big things to children in care, and young people can test out the system with small complaints before attempting to raise bigger issues.

12.136 Does the system pass the test? Would young people use it to raise bigger issues about their own safety?

12.137 Having read the assurances given in the leaflets that “making a complaint will not be held against you,” and having listened to the earnest desires of senior management that young people should be helped to raise issues of concern, it was rather distressing to here some young people who are currently looked after still give reasons for not doing so:

Can't be bothered.

Because I have to live here.

Because staff always get one up on you.

If you did make a formal complaint about anybody in here, they would make your life hell; for example against a key worker. They would give you dirty looks and not talk to you.

12.138 In one unit, the young people explained how frustration at not getting issues addressed resulted in them going on the rampage.

12.139 This vindicates the view referred to later by the Children's Rights Officer, that young people can be resistant to the idea of making a formal complaint. They have real fears about the repercussions in a place that they don't like, or that they think does not like them, or about “upsetting the apple cart” if they are in a place that they do like.

g. Statistics and Analysis

12.140 The Kent Report had recommended (Rec. 6) that complaints should be monitored and trends noted. During the public hearings, it was reported that such monitoring did take place. Any upsurge against a particular unit would be investigated.

12.141 Each individual unit was monitored. Whenever a complaint came in, it was checked against what had gone before. If this disclosed a particular concern about a Unit, the Complaints Officer would advise the Director and Head of Operations in conjunction with her line manager, and decide the best way of dealing with it. It might turn out that it was due to a particular mix of residents or to staffing changes.

12.142 Monthly statistics were compiled for senior managers. An annual report was presented to the Social Work Committee.

h. Links with Related Offices

12.143 The Finlayson/Newman recommended (Rec. 37) that collaborative and consultative mechanisms between ELRIS, the Complaints Officer and others in the Department should be extended and refined.

12.144 The Inquiry was informed that every complaint by a child is notified to the Children's Rights Officer and to ELRIS, who also receive the monthly statistics where these relate to registered units.

12.145 There was a network of meetings and communication between the Children's Rights Officer, ELRIS and the Complaints Office. Sometimes the CRO and the Complaints Officer met ELRIS at separate times. There was agreement by the department during the public hearings that the arrangements could be improved if the meetings were appropriately synchronised

i. Independent Establishments

12.146 The Complaints procedure requires all voluntary organisations providing services and receiving financial assistance from the Department to have a complaints procedure which is approved by the Department. Registered private and voluntary residential homes must have a complaints procedure approved by ELRIS and made available to residents along with details of how to contact ELRIS.

j. Establishments Outwith Edinburgh

12.147 The Finlayson/Newman Report had recommended (Rec. 35) that, where a complaint was made by a Lothian child, it should be investigated by Lothian. Child protection procedures and police investigations should be activated where appropriate.

12.148 The Children & Families Practice Notes/Guidelines 1997, which were discussed at with regard to investigations, do state that the procedures set out in them apply also to those children and young people who are looked after by the City of Edinburgh Council but placed with private or voluntary organisations or outwith the City's area. Nevertheless, during the public hearings, the Director of Social Work's report on implementation of the Finlayson/Newman recommendations indicated that Recommendation 35 had not been implemented. The explanation given in the written report (in note form) was:

While City of Edinburgh will be involved - local police and social work will lead investigation. This is particularly important if allegations involve young people from more than one authority. Edinburgh would expect precautionary suspension of a staff member during the course of investigations.

12.149 We can understand the complications that might arise if the complaint led to a joint police/social work investigation as referred to in the quote from the Director's report. Our concern is that all complaints by Edinburgh children, even if subsequently withdrawn, should be notified to the City of Edinburgh Complaints Officer, with an indication of how the person notifying it intends to pursue it, or not pursue it as the case may be. This gives the Complaints Officer the opportunity of taking the matter forward in other ways if not satisfied with the local response. This is consistent with the authority's ongoing responsibility to children boarded outwith the city.

Recommendation 104: We recommend that any complaints made by children looked after by the City of Edinburgh but boarded outwith the city, be notified to the City of Edinburgh Complaints Officer for information and action if appropriate. This applies also to complaints subsequently withdrawn.

J. Children's Rights Officer (CRO)

a. Establishment of the Post

12.150 This appointment was approved in principle in 1991 following a review of residential care, and given further consideration in 1992 after the publication of the Finlayson/Newman Report. However, no appointment was made until 1994. The post continues to be held by the person appointed then. Her remit is to ensure that young people who are looked after receive information about their rights, and to provide advocacy and representation.

12.151 The CRO reports to the Head of Operations and is outside any line management for Units or carers. She has a freephone number and a 24 hour answering machine.

b. Scope of the Role

12.152 The CRO's remit is not limited to Edinburgh, but includes Midlothian and East Lothian. She also visits other units which receive children from the City of Edinburgh. She was able to visit units less than once every two or three months. Some were visited more often than others because when she became known, young people were more likely to call her back.

12.153 She explained how, over the previous 18 months, she had been giving support to some of the victims of the abuse with which this Inquiry was concerned. We learned from them how much some of them had appreciated her support. This involvement had, however, further reduced her opportunities for contact with young people during that time.

12.154 Whilst the remit includes foster care, it was acknowledged by all that this was an aspiration rather than a reality. Foster children did receive a booklet informing them of her role and telling them how to contact her, but she did not visit them, whereas she tried to visit units regularly. She had been contacted only three times by foster children over the previous year.

12.155 She was also concerned about availability to children with special needs. These had not been specifically included in her visits. She did not want to go and solely observe. It needed some more thought to work out how her presence could be meaningful.

c. Involvement with Complaints

12.156 The CRO told us that she received copies of all complaints made by young people. However, young people did not always want their concerns to proceed as far as a formal complaint. They sometimes discussed matters with her with the aim of getting help to resolve them locally. She would try to do that. If they wanted to submit a complaint, she would facilitate that.

12.157 As discussed in Chapter 10, she indicated during the public hearings that, if a young person alleged abuse by a member of staff, the child protection guidelines would be implemented and it was possible that neither she nor the Complaints Officer would be informed. She believed it would be helpful if young people in this position were offered the possibility of personal support from herself.

d. Current Issues

12.158 Recent themes in connection with young people's concerns were:

- The use of restraint; and
- How we care for young people who are likely to abuse other young people.

e. Strategic Role

12.159 The CRO felt she was able to influence policy through her links with senior management and her collation of statistics to identify trends. She presented her own report annually to the Social Work Committee.

12.160 We studied the annual reports. Whilst these provided some interesting information on issues raised, we believe they could be more analytic with regard to these issues and any developing trends. It would also be helpful to have a report back on measures taken to address issues that has been identified in the earlier reports.

f. Development of the Post

12.161 The CRO told the Inquiry that there was no particular development plan for her post. Her preference would be for the appointment of a CRO for each social work district, still based at headquarters, and reporting to a senior manager.

g. Location of the Post

12.162 We identified a question about whether the post's location within the Social Work Department detracted from its perception as independent. Certainly, many of the past victims had indicated to us that they would have trusted no-one from the Social Work Department, no matter what their title. The Kent Report had addressed the issue and had come down in favour of location outwith the Department. Kent advocated the appointment of 15 Children's Advocates nationwide, with a remit embracing all children living away from home (not just those "looked after" by the Council) and located within an existing voluntary organisation.

12.163 The CRO expressed the view that there were advantages to her current location. Young people appreciated the fact that she had "clout with the Bosses." The independence aspect was alleviated by her extensive contact with the Who Cares? organisation who were autonomous and independent. Both she and the Who Cares? worker met regularly with ELRIS to share concerns.

12.164 Senior management indicated to us that they greatly valued the current location of the post. The office being adjacent to theirs, the CRO's presence served as a constant reminder to them of the importance of the issues embraced in her remit. They had regular,

virtually daily, contact with her. She served as their “eyes and ears” for children looked after by the Council.

h. Young People’s Views

12.165 The CRO had expressed concern about the lack of time to maintain regular contact with young people. Despite her fears, our visits to units disclosed a high degree of awareness of the Children’s Rights Officer. Many young people spoke warmly of her and responded immediately with her name when asked who they would go to with a concern. There was only one instance in which there appeared to be a hesitant response from young people. Having said that they knew and liked the CRO, they were unsure about contacting her about what appeared to be very real concerns in a troubled unit. They did not think she would be able to do anything about their concerns, and there was a hint that they thought she might be too close to staff.

i. Staff’s Views

12.166 Most staff also seemed to welcome the CRO. However, there were some divergent views. One unit manager said the post was the best safeguard the Department had. Another said it was “a bit of a fig leaf” in respect that her visits were not frequent enough to obviate the possibility of a cover-up.

j. Conclusions

12.167 Apart from these limited examples quoted, a consistent theme of our meetings with residents and staff was the high regard in which the postholder’s personal qualities and enthusiasm were held. Given the extent of her duties, we were greatly impressed as to the extent that individuals knew her by name, had met her and valued that contact.

12.168 We agree with the perception that the Children’s Rights Officer is a very significant safeguard. We would therefore be reluctant to recommend changes that might inadvertently detract from its effectiveness. We do not think there should be any change in its current location. Although victims of past abuse indicated that they would not have trusted anyone from the social work department, it is interesting to note that many of them welcomed the CRO’s support during the trial.

12.169 We do accept that there may be some cases, such as the one described above, when a particular young person or group might wish a greater degree of distance. This is where we see the complementary role of the Who Cares? organisation as a distinct advantage.

12.170 We are also of the opinion that the CRO’s role is currently overstretched. We are wary of recommending an increase in staffing that would lead to what might be seen as a more bureaucratic structure. At the moment, the officer is known to young people as a person rather than just a post, and that is important. We do believe that at least one more officer, and possibly two more, should be appointed, and we therefore recommend that:

Recommendation 105: At least one more Children's Rights Officer should be appointed. The expansion in staff should be linked with a commitment to making more contact with foster children and those with special needs.

Recommendation 106: No change should be made to the location of the Children's Rights Officers within the Social Work Department.

12.171 It is essential that great care is taken with the selection of children's rights officers. It is not a post that should ever be filled for reasons of expediency with, for example, persons requiring relocation. If the wrong people are appointed, it will lose all credibility and effectiveness.

12.172 We also believe that there should be a greater emphasis on the strategic input of the officer. We recommend above that ELRIS should develop further its role as collator of statistics about matters of concern. ELRIS already has regular contact with the CRO. We believe that a steady working relationship should develop whereby ELRIS becomes the source of the information the CRO needs to formulate strategies to improve the rights of young people who are looked after, taking into account the corporate responsibility of the whole authority for these young people.

Recommendation 107: The Annual Report of the Children's Rights Officer to the Social Work Committee should contain more analysis of issues raised with her, as well as a progress report on issues identified in the previous year's report.

12.173 We acknowledge the valuable work done by the CRO in supporting the victims of past abuse in connection with the trial. We are concerned that this reduced her availability to children currently looked after by the Council.

Recommendation 108: We recommend that, if a situation such as the High Court case were to arise again, someone other than the Children's Rights Officer should be appointed for the adult support role, or else additional cover should be provided in the office of the Children's Rights Officer to ensure that children and young people are not put at risk by the lack of availability of the CRO.

Recommendation 109: We also recommend that young people involved in allegations of abuse by a carer should routinely be offered the support of the Children's Rights Officer or other independent person.

K. Who Cares? Scotland

12.174 Who Cares? Scotland is a campaigning and advocacy organisation for young people with experience of care. It is a voluntary, charitable organisation with a national remit. It was identified by both the Skinner and Kent reports as providing a useful service for young people in care.

12.175 Who Cares? employs a number of workers allocated to particular local authority areas. Edinburgh is one of five local authority areas covered by one worker who contributed to the public hearings along with a member of the Who Cares? Board.

12.176 The Director of Social Work's written submission had identified Who Cares? as part of the external monitoring and support network for residential units. All young people were advised of the existence of Who Cares? Its identifying characteristic was that it was a completely independent organisation with free access to residential units.

12.177 The Director also advised the Inquiry that regular meetings are held between the Who Cares? worker and the Head of Operations to monitor and review the work of the postholder, and also to provide a further channel of communication on issues of concern.

12.178 At the public hearings the Who Cares? officer gave examples of some of the issues which young people had brought to his attention. He received on average one call per week from young people. Staff also phoned on behalf of particular children. He was proactive in visiting units. He had 30 units to visit and scheduled in a visit to each every 3 or 4 months. In practice, he tended to visit some units more frequently than others. He estimated that 55% of his time was taken up with children looked after by the City of Edinburgh. In addition to his practical work with young people, he was involved in policy development.

12.179 In theory his role included support for young people in foster care, but in practice this did not happen due to lack of time and difficulties in accessing foster placements. There was little response from foster children to the Who Cares? information given to them. It would be impossible to extend his visiting, or to provide a service, to the 300 foster children in the city within the limits of his present role and funding.

12.180 In his view, the priorities for development of his post included its extension to a full time Edinburgh appointment, a development of the work in foster care, increased work as an independent representative for young people attending children's hearings, and increased input into the lay inspector aspects of ELRIS.

12.181 Most of the Units visited by us received the Who Cares? literature and reported recent visits by the Who Cares? officer, some more so than others, as the officer himself had indicated. The young people knew about the organisation but the amount of interest varied amongst Units.

12.182 In the course of our work, one of us, not directly connected with Who Cares?, took the opportunity to attend a national meeting of the organisation at which young people spent a morning debating issues of personal safety for children in residential units. The themes raised by the young people mirrored those raised by Edinburgh children in the course of our work, and, in particular, what they saw as a preoccupation with and inappropriate use of restraint. They also highlighted the issue of reassuring physical contact between staff and residents. They believed that the staff were now reluctant to provide such comfort. Some clearly regretted that, though they were quick to assert that they would wish to control who provided that comfort and the limits to be applied.

12.183 The Edinburgh Who Cares? worker had attended that meeting, which took place on a Saturday and at which some 100 young people were present. None was from Edinburgh. He explained that he had wanted to bring a group of Edinburgh children who were in a secure unit, but because of staffing difficulties the unit could not arrange necessary staff cover. This

was unfortunate as the issue of children's rights and the Who Cares? organisation is particularly relevant for those children detained in the restricted conditions of secure accommodation.

a. Conclusions

12.184 We believe Who Cares? provides an independent check on residential units, whose significance is heightened where the Children's Rights Officer is located within the social work department. We recognise that young people are unlikely to take a concern to someone they do not know well enough to trust. The spread of the post, and the need for the current officer to cover four authorities, makes it very difficult for one worker to achieve a position of trust. There is also an acknowledged need to reach out to young people in foster care.

Recommendation 110: The Director of Social Work should recognise that a full time Who Cares? post is warranted for the City of Edinburgh, given the numbers of young people in residential or foster care, and should seek to identify funding for this.

Recommendation 111: The Director of Social Work should allocate resources to enable Edinburgh children to attend relevant meetings of the Who Cares? organisation.

L. Identifying and Expressing Concerns - Main Themes

12.185 Whilst some of the people involved in the processes discussed above may be "tuned in" enough to pick up on concerns themselves, the actual processes also rely to some degree on the child feeling confident and trustful enough to express concerns to them. We have made some suggestions about the processes involved. With regard to staff and other supporters for children and young people, we cannot avoid the fact that a lot depends on personalities. The relationship a person has with a child is more significant than the role a person is appointed to play.

12.186 We have referred at various points to suggestions about the appointment of additional independent persons to act as an extra check. However there is a real need to be clear about what kind of function that person is expected to perform and how it interacts with others already in the system. This matter is more fully addressed in Chapter 16.

12.187 We have already concluded, but wish to emphasise here, that the Children's Rights Officer is the most effective safeguard the Council currently has. The role should be expanded and developed, especially into the areas of foster care and special needs, where few of the current safeguards appear to exist to any great extent. Any perceived lack of independence would be balanced by increased accessibility to workers from the independent Who Cares? organisation.

12.188 Where a concern about a child's safety is identified by staff, it is important that they know what to do about it and are confident in taking the matter forward. We have discussed the welcome steps the department has taken in this regard and made recommendations to make them more effective.

13. FOSTER CARE

A. Introduction

a. Numbers in foster care

13.1 The City of Edinburgh has 317 children in foster care, as compared with 129 in residential units. 72 of the foster placements are with carers approved by voluntary organisations or other local authorities.

b. The Director of Social Work's written submission

13.2 This described its "rigorous selection and assessment procedure" for foster carers, based upon legal requirements. The submission commented that such rigour was necessary because "the nature of foster care means that young people are cared for within the carer's home without external scrutiny for lengthy periods between the visits of social work staff."

c. Research into abuse in foster care

13.3 The Kent Report included a literature review relating to abuse in foster care. It acknowledged that there had been relatively little research done in this area, particularly in the UK. Its conclusion was that "While it is difficult to ascertain the exact scale of abuse in foster care, it cannot be disputed that it occurs, and with a frequency which makes surprising the lack of detailed study."

d. The Inquiry's methodology

13.4 Our consideration of foster care was based upon meetings with staff, perusal of policy papers and meetings at the homes of three foster families. In addition, information about the Inquiry, and an invitation to contact us, was sent out to all carers. Many of the young people we spoke to in residential units also had experience of foster care which they shared with us.

13.5 We set out below a number of sections addressing issues roughly equivalent to those discussed with regard to residential care. In some cases, where the issues are common, we have merely reflected back to the earlier discussion.

B. General Provisions regarding Foster Care

a. General Standards

13.6 The Council adheres to "Quality in Caring - Standards for Fostering and Adoption Services" initially devised by the former Lothian Region. These set out clear performance indicators in relation to the child's experience, the profile of carers, the environment and agency responsibilities.

b. Recruitment

13.7 The department supplied us with extensive paperwork detailing the selection process for foster carers, from the initial enquiry by the prospective carer to registration and matching with a child. This involves police and medical checks and compliance with other legal requirements.

13.8 Senior social work staff indicated to us the difficulties in recruiting sufficient foster care placements. Asked what the priority recommendation should be with a view to making foster care safer, one replied:

We should make sure we had a recruitment capacity that took us to 90% occupancy so that we had choice. At the moment we have 110% capacity, so we have no choice. We are not recruiting in the market place with a scheme attractive enough to attract people.

13.9 We were reminded by staff that foster carers cannot be recruited in isolation from other staffing developments; the greater the number of foster carers, the greater the need to recruit more skilled staff to support them.

c. Training

13.10 We were informed that all carers underwent training on sexual abuse and safe caring. "Safe caring" involves creating a safe environment in the home which sets clear boundaries and expectations, for example about physical contact, privacy, dress and being alone with a young person.

13.11 During the public hearings the Planning, Purchasing and Commissioning Manager (Children and Families) indicated that it might be appropriate to train foster carers in a more structured way with reference to HNC/SVQ.

13.12 While some children looked after by the Council need little more than good quality, caring, substitute parenting, others have more complex needs. Whilst we believe the current level of training undergone by foster carers is a significant safeguard, we have met some young people who would benefit from more specialised foster placements where a higher degree of training and support is required. We know that the department is aware of this and have no specific recommendation to make in this regard.

d. Supervision and Support

13.13 The Quality Standards document sets out as its target the situation in which:

Support, training and supervision are provided by a variety of means, including contact with appropriate Social Work staff, topic-based training, peer group support, consultation with specialist professionals, personal counselling, outside consultancy and discussion with other carers.

13.14 Support for carers is provided by a Resource Team Worker, whilst that for the child is provided by the child's own social worker. This ensures that neither supporter has a conflict of loyalties.

13.15 During the public hearings the Planning, Purchasing and Commissioning Manager (Children and Families) indicated that work was also underway to link foster carers with Young Peoples' Centres as a source of support.

C. Identifying and Expressing Concerns

a. Social Workers

13.16 The theory is that the child's own social worker is the support for the child. During the public hearings, the Planning, Purchasing and Commissioning Manager (Children and Families) noted that there were 10 foster children with no allocated social worker.

13.17 After the initial placement, the frequency of contact between child and social worker varies, although most social workers visit fortnightly. It was acknowledged that there was a danger of the child feeling "out on a limb." This was not because that kind of support was not appropriate, but because practice team staff found it difficult to allocate the time required to ensure continuing oversight and to build up a trusting relationship with the child.

13.18 This view was supported by a group of social work staff we met with who said that, in their view, foster children were more vulnerable than those in residential care. Recently, the more serious cases of abuse had arisen from foster care rather than residential care. During the course of our work, one foster parent who had fostered Edinburgh children, although resident outwith the city, was sentenced to substantial term of imprisonment for sexual offences against children, including his foster children.

13.19 However, the staff group told us that practice team workers were beleaguered with child protection cases, duty, etc. It was more difficult to find time to be a regular feature in a child's life than it had been in the days when social workers had a generic case load. There were also issues relevant to the nature and extent of support offered by the practice team worker. Although designated as the child's support, sometimes the social worker would devote more time to talking to the carer. Workers needed to ask children the right questions and give them time to talk. They needed to be clearer with children that it was OK to raise safety issues with them.

13.20 The lack of time social workers had to carry out these responsibilities raised again the issue of whether independent persons should be appointed to fulfil this role. The Planning, Purchasing and Commissioning Manager (Children and Families) expressed concern at the idea of introducing another "independent person" into the child's life. How could one be sure that the independent person was trustworthy? It was also possible that the child's life might become crowded out with people, which could be unsettling, especially where the foster placement was long term and there was a need to normalise it. Constant questioning and search for reassurance that all was well could detract from the child's necessary feeling of security.

13.21 Senior social work staff expressed their opinion to us that the lack of foster care placements had a knock-on effect on safety issues. They said there was a dilemma for resource team workers in that they were responsible for providing sufficient placements, and

for giving support to the carer. In the Inquiry's view, this could lead to over-optimism about the ability of the carer to cope, and underestimation of the significance of any concerns.

13.22 This issue is relevant to the discussion later in this report, at Chapter 16, about independent persons, and our Recommendation 123 in that regard.

D. Dealing with Difficulties

a. Investigation of Complaints or Allegations against Carers

13.23 The Children & Families Practice Notes/Guidelines 1997, discussed in Chapter 10 with reference to residential care, apply also to substitute family carers, with appropriate modifications. The District Manager has the responsibility for deciding whether a carer's approved status may continue during the investigation, or whether it should be temporarily suspended.

13.24 If a formal investigation follows then, unless the allegation is judged to be completely unfounded, it will lead to a review by the fostering panel of the carer's status.

13.25 There is a danger that the potential for over-optimism referred to above with regard to social workers, could also apply to the investigation process. There are safeguards built in, in respect that, as the Director of Social Work's submission stated:

Where an allegation is made against a foster carer then investigations are generally undertaken by a manager from outwith the foster carer's district or management so that there is an external person considering the child's needs.

13.26 In later meeting, senior managers explained the significance of "generally." If the allegation was about something relatively inconsequential, such as a clothing allowance, it would be kept within the district. If it was an allegation of abuse, it would be investigated externally.

13.27 However, a former employee reported to us a concern with regard to an allegation by a young man with a mental age of 9, against his community carer who was also a foster carer. The young man had been removed from their care. The matter was reported to police, but no action followed. According to the former employee, the department did instruct an internal investigation, but, against guidelines, this was carried out by workers from the district within which the carers operated. The carers were highly regarded as foster parents, although one social worker had expressed reservations as to their suitability. The concern was that the failure to carry out a more independent investigation left children placed with these carers at potential risk.

13.28 We have not investigated this allegation. However the scenario it presents does underline the need for a completely independent investigation of foster care allegations.

<p>Recommendation 112: We recommend that investigations into allegations against foster carers be carried out by an independent person with no responsibilities for foster care provision in the area.</p>

b. Behaviour Management

13.29 The Quality Standards document promotes the outcome that:

Children and young people's behaviour is managed in context by carers who operate within agreed strategies for this. Children and young people are helped to internalise a sense of right and wrong through empathic and rewarding care.

c. Transmitting Concerns

13.30 The Orkney Report (Paragraph 17.33), in its discussion of how children can be encouraged to tell about abuse, commented on the contribution of foster carers. It said :

A child may more readily tell of his or her distress in a domestic setting than in the confines of an interview.

13.31 It seems to us that this statement can be generalised to the extent of placing an explicit value on the observations of foster carers with regard to measures likely to promote the child's welfare. A former employee told us about a situation in which foster carers had attempted to express their concerns about a proposed adoptive placement for a child, but felt they had not been listened to. They had then contacted our informant, who had by then moved to another area of work within the department, in the hope that she could take up their concerns. We were told that the foster carers had been issued with a warning about breaching confidentiality in this way. We have not investigated this allegation. However it seems to us that it raises a general point which is that, given that so much care has been taken to recruit and train the carers, the views of foster carers who have had significant contact with children, should be taken seriously.

<p>Recommendation 113: We recommend that the Director of Social Work evaluate current practice with regard to response to concerns expressed by foster carers about children and young people they have looked after, with a view to ensuring that this takes appropriate account of the valuable insights they may be able to contribute with regard to the welfare of those children.</p>

E. Keeping Watch

a. Inspection

13.32 Foster carers are subject to vetting on appointment, and certain material standards are required of foster homes before approval. However, they are not subject to the regular and formal inspection of ELRIS in the way residential units are.

13.33 The Kent Report had observed:

I have no evidence that this is the case but it is possible that children in foster homes are more vulnerable than children in residential settings. There are fewer officials visiting and Children's Rights staff do not find it easy to go in. Foster caring should be brought within the inspection process. One Scottish region has done this on a pilot basis and with success.

13.34 During the public hearings, the Director of Social Work indicated that bringing foster care within the inspection process could act as an additional safeguard. However, it had to be recognised that there would be major resource implications. Possibly in recognition of

this, Kent suggested that “Perhaps this should concentrate on the arrangements for fostering, but I would want inspectors to at least meet a sample of carers and children.”

13.35 During the public hearings, the Head of ELRIS questioned whether sampling would be sufficient. The Literature Review attached to the Kent Report had suggested that children in alternative families were highly vulnerable. They should have the same protection as other children.

13.36 Involving the inspection service would have the benefit of introducing a skilled, independent assessment separate from the ongoing monitoring by social work staff. It would be an antidote to the tensions resulting from the dual responsibility of resource team workers in recruiting and supporting foster carers. It would act as a counterbalance to the perspective of the weary social worker, who may recognise that the placement is not ideal but proceed because it is all they have got. Quite simply, if the placement is not good, it is not good enough. In some cases the risks attached to remaining at home may be less than the risks of an unsatisfactory foster placement. Inspection carried out sensitively would also give foster carers the opportunity to comment on the service and support provided by the department.

<p>Recommendation 114: We endorse Kent’s proposal that foster care be brought within the inspection process. All foster care placements should be inspected. We recognise this may need to be phased in.</p>

b. Visits by Management or Council Members

13.37 These do not take place within foster care. Indeed, it would be questionable whether regular visits of this kind would be appropriate in a domestic setting.

c. Reviews and Children’s Hearings

13.38 We reflect back to our observations and recommendation at ... above relating to the possible inhibiting effect of carer’s continuous presence at these forums.

d. Support through the education system

13.39 We reflect back to our observations and recommendation at ... above relating to this matter.

e. External links through activities and befrienders

13.40 The Quality Standards document encourages involvement in external activities. We have not done an extensive enough audit of this to ascertain whether this expectation is fulfilled. One of the foster parents we spoke to actively encouraged the child’s participation in a judo club, which she thoroughly enjoyed. Inspection would allow an opportunity to assess whether the standards were being complied with.

f. Client Services and Complaints

13.41 As indicated in Chapter 12 with regard to information about the Complaints service, two out of three carers did not know about the complaints procedure. We have made appropriate recommendations within that section of the report

g. Children's Rights Officer

13.42 As indicated in Chapter 12, the Children's Rights Officer did not visit foster placements on a planned basis. We have made appropriate recommendations within that section of the report

h. Who Cares? Scotland

13.43 As indicated in Chapter 12, the Who Cares? officer did not visit foster children on a planned basis.

13.44 There are very practical explanations for this situation with regard to the CRO and the Who Cares? officer. As the Who Cares? representative pointed out, he is already stretched trying to keep in contact with 30 residential units. It would be impossible to extend visiting to 300 foster placements. A more practical solution would be to arrange for gatherings of foster children to provide mutual support and to open up channels of communication, but that too presented problems. Foster children tended to be younger, and there could be practical difficulties in getting them together. Even communicating with them was problematic.

13.45 In an interview held outwith the public hearings, senior members of staff of the Social Work Department indicated that it was difficult to get children in foster care to go to Who Cares? meetings. They were considering building information on Who Cares? into foster carer training. Our Recommendation 111 above is relevant to this difficulty.

F. The Vulnerability of Foster Children

13.46 Foster children are the youngest, most vulnerable and most isolated group of looked after children. In many ways, their age and situation is more akin to that of the children who were subject to abuse in the High Court cases than are those in residential care today.

13.47 It was clear from our investigations that children in foster care had the greatest potential for isolation from outside sources of help. Some carers, and presumably the children themselves, many of whom were very young, seemed unaware of the complaints procedure. It might be more difficult for foster children, especially younger children, to have the possibility of making private phone calls. The CRO did not visit. Who Cares? Scotland did not visit. These officers themselves recognised the need to reach out to foster children, but felt unable to do so within the limited time available to them.

13.48 We found ourselves faced with similar dilemmas. How could we contact foster children in a way that made sense to them? Would it be too intrusive for us to visit their homes? To what extent should we involve their carers? How free would the children feel to speak to us?

13.49 In short, it is generally recognised that we do not do enough for foster children. This is a national problem, not one particular to Edinburgh.

G. The Carers' Perspective

13.50 During our visits we noted that the support given by the carers to the children was impressive. They in turn spoke well of the support they received from the Department and of the support the children received from their social workers, all of whom visited regularly. The responses to other areas of questioning tended to fall into a pattern of two out of three responding positively, with different carers giving more negative or muted responses to particular matters. This applied to: the perceived thoroughness of the carers' assessment; their own preparation to receive children; and their own support from resource workers. As indicated above, only one of the three knew about the complaints procedure. Only one spoke enthusiastically about the value of support groups.

13.51 The male carers expressed some anxiety about physical contact with their foster children. The training on "safe caring" provided by the Barnardo's Skylight project was well thought of.

13.52 Two of the carers suggested that unannounced visits by social work staff would be an added safeguard. Currently, they were invariably courteously informed before all visits by field and support workers of their intention to call. In their view, this predictability of visits could allow carers to cover up any inadequacies in their standards of care.

<p>Recommendation 115: We recommend that field and support social workers should make occasional unannounced visits to foster placements.</p>

H. Encouraging Carers

13.53 Our dilemma as an Inquiry team is that our conclusions relating to foster care risk reinforcing a vicious circle which could work to the disadvantage of children. It seems clear to us that foster children are vulnerable and that there needs to a greater awareness of this and a specific emphasis on reaching out to them and ensuring that they are properly supported. It is also clear that some of that vulnerability arises from a lack of choice and availability of placements. If we identify foster care as a major area of concern about potential abuse, we might put people off doing the job. Social workers told us that it became more difficult to recruit after a court case.

<p>Recommendation 116: We recommend that, with a view to diluting concern that they may experience by implied suggestions that they are under suspicion, support workers should take the opportunity to inform foster carers of the substance of this report so far as it relates to fostering, including the observations that the Inquiry has made about the value of and need for fostering, and its recognition of the importance of their receiving high standards of relevant training and support.</p>

I. Foster Care - Main Themes

13.54 Foster children are excluded from many of the safeguards currently available for other children looked after by the Council. This is a matter of great concern. Efforts must be made to extend these safeguards to them.

13.55 Foster carers need to know about complaints procedures and the roles of the CRO and Who Cares? so that they can advocate on children's behalf and also encourage children themselves to communicate concerns.

14. CHILDREN WITH SPECIAL NEEDS

A. Methodology

14.1 Our consideration of the particular situation of children with special needs was addressed through paper research, visiting a residential establishment catering for young people with special needs, and discussions with staff of that unit and the manager of the project running it, which was part of a large voluntary organisation. We also followed up with one of the young people a report of a complaint she had made bearing upon her welfare and, potentially, her safety. This was discussed in the context of corporate responsibility in Chapter 8.

B. Vulnerability of Children and Young People with Special Needs

14.2 Some of the victims of abuse leading to the establishment of the Inquiry were classified as having had special needs as children. Lesson 66 and 67 from the past focus on this.

14.3 Whatever may be the difficulties experienced by the general population of “looked after” children, by younger children and by foster children, the added complication of special needs makes them even more vulnerable. Some will require physical assistance which will accustom them to being touched in such a way that they might find it difficult to distinguish legitimate touch from abuse. Some will have communication difficulties which will make it difficult or even impossible for them to tell about experiences they are unhappy about. Some may be initially more receptive to abusive behaviour on the basis of being offered treats or bribes, and therefore experience feelings of guilt and reluctance to tell about the abuse.

C. Legal Status and Impact on Safeguards

14.4 There is an added complication in that some special needs children will be living away from home on the basis of an education assessment and may therefore not be classified as “looked after.” This means that they will not benefit from some of the safeguards such as scrutiny by reviews or children’s hearings, or contact with a social worker, the Children’s Rights Officer or the Who Cares? organisation.

14.5 Our enquiries indicated that there were 36 Edinburgh children placed in residential educational establishments under education provisions and therefore not technically “looked after.” Where children were placed in establishments for social, educational or behavioural difficulties, they would nowadays be subject to a joint social work and education assessment, with the result that most would then become “looked after” on a voluntary basis. However, it was indicated to us by the Social Work Department that there might be a few young people resident on this basis who were placed before the current arrangements were established and who would therefore not be classified as “looked after.”

14.6 The Kent Report recommended (Rec. 8) that:

The help of Children’s Rights Officers should be available to all children living away from home, not exclusively the looked after population alone.

14.7 It is a matter of concern that there may be children living away from home on the authority of the Council who are not protected by the safeguards afforded to looked after children.

Recommendation 117: We recommend that the Council take steps to identify those children living away from home on the authority of the Council, for example for educational reasons, who do not have the inbuilt safeguards afforded to “looked after” children, with a view to ensuring that, as far as possible, the same safeguards are extended to them.

14.8 There are also special needs children who are technically “looked after” in terms of the Children (Scotland) Act 1995 because of their involvement in respite care or “share the care” arrangements. The Social Work Department was anxious to avoid unnecessary intrusion into these families on the basis that the children were in their own homes most of the time and their own families were their strongest external links and advocates. We agree with this sentiment. The fact that the children are involved in respite care means that there is some avenue for adults who know the child to pick up any concerns about care in the home. The parents themselves will be in a good position to pick up concerns about inappropriate behaviour during respite. To this extent, the parental care and the respite care with regard to these children can act as checks upon each other.

D. Identifying and Reporting Concerns

14.9 Where children and young people have communication difficulties arising out of their special needs, there is a dilemma in respect that the people best able to communicate with them are their carers, and it is the carers who are in the best position to perpetrate abuse. One cannot be confident that effective safeguards have been introduced unless those charged with the task have earned the confidence of the child and young person *and* are able to communicate effectively with them.

14.10 As indicated above, we believe that children and young people involved in “share the care” arrangements already have at least two potential avenues for communication which can act as checks upon each other. Other special needs children and young people who are looked after by the Council also need to have at least two independent persons with whom they can communicate to the best of their ability.

14.11 This was an issue for the Children’s Rights Officer who expressed during the public hearings her own concern that any contact with special needs children and young people should be meaningful. She felt that her mere presence as an observer with little possibility of communication might not be particularly helpful and might engender a false sense of security. This was also an issue for us as an Inquiry team. We were reluctant to intrude on the private lives of children and young people if we had no real possibility of communicating with them effectively.

Recommendation 118: Where children and young people with special needs live away from home, the Director of Social Work should ensure that, in addition to those caring directly for the child or young person, there is at least one other person who is a regular visitor to the child and who can earn the child’s confidence and communicate with the child so far as the child’s disability allows.

E. Investigations

14.12 When children and young people with special needs do tell about abuse, they may have even greater difficulties than others in being believed. Even when they are believed, there may be reluctance to act on their accounts due to concerns that they will not be good witnesses. All of these factors were evident in some of the past cases that formed part of our remit.

14.13 A worker from a voluntary organisation told us that social work insight and support was variable. For example, some offices were reluctant to involve special needs children in joint interviewing in connection with child protection processes because they felt they would not get useful information and the child might not be a credible witness. Some progress had been made recently through the Social Work Department's appointment of children's disability social workers.

14.14 The concerns about effective communication with special needs children in a child protection context need to be addressed nationally. The Department's appointment of children's disability social workers is a step in the right direction.

F. Special Needs - Main Themes

14.15 Whilst we have but briefly addressed the issues relating to children with special needs, we have learned enough to lead to an uncomfortable awareness about their special vulnerability. We have made some recommendations about their specific needs which supplement the more general recommendations below with regard to independent persons.

15. INAPPROPRIATE PLACEMENTS

A. Introduction

15.1 We referred to this matter in Chapter 8 in connection with the issue of risk taking. We indicated that a major theme running through the staff response to the Inquiry's investigations was that inappropriate placements posed a serious threat to the safety of children looked after by the Council.

15.2 This section of the report seeks to explore the Council's provision of resources for looking after children, the threat posed to children and young people from other residents, and finally to two specific examples of facilities which we consider are being used inappropriately for the care of children in Edinburgh.

B. Resources

15.3 It became clear during our consultation with staff and senior management that the Department faces major difficulties in finding appropriate places for all young people to live when they are separated from their families.

15.4 The following are quotes from staff members:

Lack of resources is the biggest abuse. Kids are at risk here all the time. Staff have said to field workers "This is not a safe place for this young person at this time." But it's a bed.

I feel a party to an abusive system where I can't protest.

With large numbers you are just always trying to keep the lid on things and the level of abuse within the group heightens.

There is a whole host of systematic abuses of children that don't hit the headlines. We move them from placement to placement. Some kids have five foster placements in a year and people are surprised that they need locked up.

What's the point of keeping a kid if you can't make things better?

If the start isn't right it takes us too long to catch up. They're moving them from home to reduce the risk, but sometimes they move in here and the risk is increased.

Places like this exist to provide safety and care for young people. Anyone placing a young person here has a responsibility to assess whether the young person will be safe here or not. I don't think that assessment is done often enough.

The reasons for coming can become lost because the young person gets caught up in a system that generates its own new set of problems and they become the focus.

Sometimes young people come from other YPCs [Young People's Centres]. You have to ask – are we offering them anything that we haven't offered them already?

The resource situation is dire. Children are put in where there's a bed, not necessarily where it is the best place for them. We feel we are in the worst position we have ever been in with resources. We know we are not matching children with the right resource. There are a number of children awaiting immediate placement who really should not be in the community. Also a number of children in completely inappropriate placements. They can have a string of temporary placements.

15.5 We found evidence of children in residential care who, their carers and we believe, would have been better matched with a foster placement which could not be obtained because foster placements are also in short supply.

15.6 There is a real dilemma for the department in finding appropriate places. The question is whether priority should be given to opening more units and finding more foster placements, or focusing on preventative work and providing more community based supports, as is suggested above in relation to risk taking. Whatever the quality of preventative work, some children will require residential placements.

15.7 The Kent Report had recommended (Rec. 60) that "Every step should be taken to ensure that there is always a choice of placement. Greater use should be made of the Centre for Residential Child Care's data base of resources." It would certainly seem appropriate to consult the database for assistance.

15.8 A senior manager explained to us the difficulties that can rise when a child is placed in a residential unit in face of a unit manager's belief that it was not an appropriate placement, either in the child's interests or because of concern as to the child's impact on the care of other children in the unit. A self-fulfilling prophecy could produce breakdown. Whereas he felt most unit managers were sufficiently professional to counteract this tendency, recognising that available alternatives might be even less appropriate, the dangers were real.

15.9 Merely increasing the number of foster carers would not provide solutions. A matching increase in professional staff would be necessary to train and support them. Some particular children for whom foster placement would appear to have been more suitable than residential placements, especially those of tender years, presented behavioural and care problems which would require very highly able foster carers.

C. Abuse by Other Residents

15.10 This is a sensitive issue. We would not wish to spread a false idea that young people in the care system are dangerous or bad, nor that they can easily be separated into abusers and victims. Young people are placed away from their families for many different reasons. Some of them may have particular difficulties; some may themselves have been abused.

15.11 The Kent Report had noted that "abuse of young people by young people needs wider discussion..... Abuse by peers, both physical and sexual, seems to be much more prevalent than abuse by carers. There are dilemmas about having an abused child and an abusing child in the same residential unit."

15.12 However, Skinner had expressed the opinion (Summary Point 12) that it was unrealistic to seek always to separate abusers from abused. The groups may overlap.

15.13 Adolescence is a critical time for children's sexual development. Experimentation is to be expected. The borderline between experiment and abuse may be a narrow one. Recognition of these factors and responsibility for caring for adolescent sexual development adds to the complexity of the carer's role.

15.14 The issues are not limited to sexual abuse, but may extend to bullying and intimidation. The size of units may be a factor in this. Whilst unit sizes today are much smaller than the large institutions of the past, some staff feel that those which accommodate 10 - 12 young people are still too large. When they are placed into larger units, what was described by one member of staff as a “youth club sub-culture” can develop with an unhelpful dynamic. A home for four, with perhaps one extra respite place, was felt to be more manageable. We recognise that, while four may be the ideal, staffing costs would escalate enormously.

15.15 Some young people raised with us concerns about bullying and aggressive behaviour. We saw a few examples of physically stronger children appearing to dominate and, on one occasion, a child striking a younger one. Such actions could be seen as a natural part of growing up, and we recognise that incidents of such behaviour are to be expected. Many parents have to cope with this experience within their families. Again, the issue becomes more complex when children are forced to live together in an “unnatural” family. Some children told us of feeling intimidated at worst and grossly inconvenienced at best by their co-residents.

15.16 Concern about abuse by other residents was expressed to us by staff, who described a number of particular instances to us. The isolated examples provided to us by residents may have been attributable to the fact that we generally spoke to young people in groups which presented difficulties for them in talking about it. They were offered the possibility of speaking to us privately, but few took that up. This did not surprise us given our thoughts on the role of external or independent people which is discussed further below.

15.17 It did seem however that complaints about other residents were a significant and possibly increasing issue in the work of the Complaints Officer and the Children’s Rights Officer.

15.18 Some staff felt that the issue could be addressed to some extent in admission policies. Most units complained that admissions were not planned. Some felt there should be more discussion about whether a particular young person would fit into the unit. Some felt units should have choices about admissions. However, it was acknowledged that there were dangers in that. When that system had operated in previous years, social workers would promise units that a young person presented “no management problem” in an attempt to secure them a place. Children whose behaviour presented challenges would fail to gain places. Unit staff would naturally prefer to maintain a stable unit where they could best meet the needs of current residents.

15.19 Admissions policies have some relevance insofar as they are related to the statements of functions and objectives which units are legally required to have. However, given the nature of the problems faced by many young people in residential care today, we believe the risk could be lessened by a further reduction in the size of units, combined with a greater emphasis on respite and outreach to families in the community. We therefore make no specific recommendation on this point but refer back to Recommendations 2, 3 and 4 above.

D. Outworkers and Niddrie Family Resource Centre

15.20 Two establishments in particular raised considerable concerns about the inappropriateness of placements and the potential impact on the safety of children and young people. These were the Outworkers facility located as part of the complex at Howdenhall, and the Niddrie Family Resource Centre.

a. Policy on Under-12s

15.21 The issues raised bear in particular upon the needs of the under-12 age group. In line with Skinner's recommendation (No. 4), the Council's stated policy (referred to in Chapter 8) is that under-12s should be kept out of residential care unless exceptional circumstances apply. Foster care is regarded as a more appropriate option for those who cannot for whatever reason remain within their own families.

15.22 In particular, a March 1996 "Report on Review of YPCs/CSUs" says: "8-12s are particularly vulnerable to sexually abusive behaviour from others in care."

15.23 Nevertheless, given that exceptional circumstances do arise, the Council had identified one particular unit - Balerno - as the resource for under-12s. Our own visit to Balerno disclosed that it accommodated six young boys. The unit had basically evolved around their needs. There was a lack of appropriate places for them to move on to. They were "stuck" and this affected the possibility of the unit accepting new admissions, particularly of girls who, it was thought, would experience difficulties if admitted to the unit as currently constituted. We make no criticism of the unit itself or the staff, but highlight the unit's role to reflect the situation particularly as it is relevant to the Outworkers Unit and Niddrie Family Resource Centre.

15.24 The situation with regard to under-12s is particularly important in the light of the Lesson 2 which we drew from the past, to the effect that the children involved were often so young when the abuse started that they did not realise it was wrong.

b. Remit of Outworkers and Niddrie

15.25 Initial information presented to the Inquiry suggested that the Outworker resource and the Niddrie Family Resource Centre were not strictly speaking "residential care." The original intention had been that they should provide short term, emergency facilities to help prevent children and young people coming into the care system. This was to be achieved by making available staff who could undertake outreach work within the family's home and, where necessary, provide a very short term residential facility to accommodate children until they could either return to the family home or until a suitable placement was obtained. As originally conceived there was an expectation that, for the majority of children, a return home after one night or a weekend would be feasible.

15.26 During the public hearings, the Director of Social Work explained that the outworkers service had been designed to provide:

1. Residential respite for up to four children;
2. A day service for the local community; and

3. A flat for parents and their children to stay for up to 8 weeks at a time.

15.27 Functions 2 and 3 worked well. There had been problems about function 1. It had been designed to provide short term placements for younger children, limited to a 24 hour stay during the week, or 72 hours at the weekend. However in a significant number of cases this time span had been exceeded, as discussed below.

15.28 He also acknowledged concerns about the Niddrie Family Resource Centre which had been designed for children aged 12 plus, but had sometimes accommodated children as young as five.

c. Current Function

15.29 In the course of our enquiries it became apparent that a number of former and current staff of these establishments (particularly the Outworkers) were very concerned that the original role and function of the units had become less clear, and that some children and young people (often very young children) were remaining in these units for extended periods, often of several months duration. A high level of concern was expressed that these units had become, by default, additional residential units for the under-12 age group. This was significant because these facilities were neither designed nor resourced to meet the needs of this particular group for extended periods of care. They also still continued to take in older teenagers who presented different challenges. Babies and toddlers were also received on a shorter term basis. This did not provide the kind of environment one would wish for any of these groups if in fact some children became longer term residents. Staff were not trained for this kind of work. Restraint was a common issue in the unit.

15.30 We were told of cases in which senior management had insisted on placements within these units when nothing else was available, overriding previous undertakings that no further placements would be made at that time.

15.31 Inspection reports had raised concerns about a lack of clarity with regard to the remit of these establishments. Managers spoke of the difficulty of trying to ensure that the services were maintained as short term provision, while faced with the reality of having at times to make decisions to ensure that children had somewhere to live. The pressures inherent in caring for children where the staff team itself was small made it impossible for them to concentrate on their stated aim to provide outreach support which would prevent other children being received into care.

15.32 Our contact with the units, with senior managers responsible for overseeing the units, and with the inspection team highlighted that there had in fact been several instances of children, some as young as seven or eight, spending an extended time in these units. For example, Table 1 below sets out details of the younger children resident in the Outworkers Unit from March 1995 to March 1998.

Table 1: Children Resident at the Outworkers' Facility

Ref.	Age	Gender	Placement Length	Next Placement
1995-96				
A	7yrs	M	10 months	Balerno CSU
B	2yrs	F	2 weeks	Foster Carers
C	9yrs	M	2 months	Voluntary Organisation
D	10yrs	M	2 weeks	Niddrie FRC
E	5yrs	M	12 days	Niddrie FRC
1996-97				
F	7yrs	M	3.5 weeks	Balerno CSU
G	7yrs	M	7.5 weeks	Returned home to mother
H	10yrs	F	10.5 months	Foster Carers
I	8yrs	M	6 months	Foster Carers
J	12yrs	M	2 months	Foster Carers
K	13yrs	F	2.5 months	Foster Carers
L	8yrs	M	5.5 months	Voluntary Organisation
1997-98				
M	9yrs	M	5 days	Niddrie FRC
N	13yrs	M	7 days	Returned home to mother
O	7yrs	F	7 days	Returned home to mother
P	11yrs	M	2.5 months	CSU
Q	5yrs	M	7 weeks	Foster Carers
R	10yrs	M	7 days	YPC
S	6yrs	M	9 days	Foster Carers
T	9yrs	M	6 months to date	

15.33 Often these children had been through very traumatic experiences, and exhibited extremely challenging behaviour. In some instances, they were described as being violent to other children and young people, or to staff, or as endangering themselves. One young boy claimed to have been sexually abused. Others had been physically assaulted. The situation was not a "safe" one for young children.

15.34 One 10 year old girl who we understood to be a child who was preoccupied by sexual matters was resident for almost a year. During that time, the unit cared on a short term basis for many troubled male adolescents, some as old as 16. Staff were rightly concerned as to their ability to protect the child from the interests of these adolescents.

15.35 Staff also vividly described the tensions of trying to provide a stable, secure environment for the children and young people who had to live there over a period of time, while also having to cope with emergency situations. There were difficulties involved in having a mix of very young children with older teenaged young people.

15.36 During the public hearings, the Director of Social Work indicated that, whilst 61 of the 80 Outworker placements the previous year had complied with the stated remit in respect that they had lasted for less than 24 hours, others had been lengthy. One child had stayed there for over three months. The department considered this to be unacceptable. There were currently three children resident there on a longer term basis. Two would be moving within the forthcoming week.

15.37 He also acknowledged the concerns about the Niddrie Family Resource Centre resulting from placement of younger children. This was not ideal, as they might be placed alongside children aged 15+. The problem arose because some children presented such a challenge to foster carers that there were no appropriate resources for them. The possibility of recruiting specialist foster carers for this group was being examined.

15.38 The Kent Report had commented (at paragraph 4.4) that, despite stated policy to keep under-12s out of residential care, we had not eliminated them from the children's home population and ran the risk of not meeting their needs properly through failure to plan for them. The scenario outlined above would seem to bear that out. We recognise that many of the children present special difficulties. These very difficulties, and their consequent needs for specialised and expensive care, demonstrate the need for a concerted professional examination to be made as a priority.

d. Physical Location

15.39 Inspection reports had also highlighted concerns regarding the physical location of the units. We shared that concern. The Outworkers are placed within the Howdenhall complex, a former Assessment Centre, with all the historical connotations that that building presents. The Niddrie Family Resource Centre is in a depressed area where the neighbours themselves hold the establishment in low regard, partly as a result of its historical past. We were told it would be safer for us to leave our car in the street. On no account should we leave it in the precincts of the unit. The children, some of whom are long term residents, are living in a fortress-type situation.

e. Staffing Issues

15.40 We identified several concerns about the staffing of these units. The Outworkers had been without a manager for a considerable period. There was a high use of temporary/Locum staff in both establishments. In one of the units, 20 temporary staff were used in one week alone. The Locum was virtually a full time member of the staff group. The lack of a settled staff team detracts from the unit's ability to provide a stable environment for residents.

15.41 Some staff felt totally ill equipped to deal with babies and toddlers, yet had been in a position of having to work with them at short notice. The Locum was seen to be the "baby expert."

15.42 Male staff felt vulnerable in terms of having to undertake bathing, nappy changing etc., in situations where they could be left alone due to the demands being made by other residents and low numbers of workers - especially if some staff were engaged in outreach visits. We were forcibly reminded of the number of abusive incidents which took place at Dean House while children were bathed (Lesson 16). That is said not in any way to suggest that staff here have acted wrongly. The potential for allegations against them was raised by them, not us. We believe they were acting responsibly in recognising the dangers.

15.43 At the Outworkers project in particular, staff morale had been critically low at various points. Industrial action had been considered. Sickness levels were higher than elsewhere.

f. Management

15.44 The two units are currently managed by separate Districts. Arising from the expectation that the Outworkers provision would be, and to an extent is, an adjunct of the Emergency Social Work Service, line management is vested in the Emergency Social Work

Services Manager, who reports to the District Manager for Edinburgh North Districts. Niddrie comes under the aegis of the District Manager, South Districts. The units serve the whole of the city.

15.45 We appreciated that there were welcome levels of co-operation between the two Districts. The assistance provided to Niddrie by the Service Provision Manager of the other District was much appreciated by them. So long as the units remain in their present form, there would be advantages in limiting line management responsibility to one District. That line management could also include Balerno Close Support Unit. These advantages could include a Departmental awareness of the extent of the use of and demand for residential provision for children under the age of 12; consistency in admission and practice procedures; concentration on eliminating the dangers to which we have referred; focus appropriately on the most critical cases of individual children, and production of regular, detailed statistics which could form the basis of the information which we have suggested should be submitted to the Council on a regular basis.

g. Access to External Assistance

15.46 Although some staff had information on Who Cares?, this was not up-to-date, and the units were not on the list of the Who Cares? worker.

h. Achievements

15.47 The above represents the very bleak picture which was painted in advance of our visits. While the visits confirmed a number of issues, particularly in relation to location, type of building and to an extent staff morale, we were nevertheless heartened to find that existing staff had clearly worked very hard to provide a bright, pleasant environment for the children and young people, with efforts being made to make unsuitable buildings as homely as possible, and to provide age-appropriate toys and games.

15.48 It was also clear that, despite the anxieties and frustrations of dealing with very difficult situations, and in some instances with less than appropriate placements, the staff in the Outworkers unit had succeeded in holding on to some very troubled children and had in fact been successful in effecting some change in their behaviour so that the children were able to move on to appropriate placements. For example one child, who had been resident for six months, presented huge challenges to staff. Though still on occasions very demanding, his behaviour had so modified as to enable him to spend the bulk of his time at home with his mother. She required the outreach element of the unit to support her in caring for her son while at home.

15.49 It appeared to us that the staff themselves had not always recognised their achievements, and had perhaps not been helped to do so. Recent changes in unit management and the appointment of staff on a permanent basis had begun to instil greater confidence.

i. Conclusions

15.50 We are aware that the role, purpose and function of these units has been under review for some time, and that their future will be the subject of continuing discussion. However, there are some points which we feel should be taken into account:

Recommendation 119: The Social Work Department's review of the functioning of the Outworkers project and the Niddrie Family Resource Centre should be brought to a speedy conclusion, with a clear statement on the future of the units. This should clarify the functions and objectives of the units, ensure that a suitable staffing complement is available, with the correct mix of skills and experience needed for dealing with the age range identified for the units. This review should (a) take account of the Inquiry team's concerns about the physical location of the present buildings; (b) take steps to clarify the external management of these facilities, in order to achieve a consistent approach to authorising placements; and (c) ensure that information about the Children's Rights Officer and Who Cares? is provided as a matter of course within these facilities.

15.51 We were left with the clear impression that while stated policy is not to have under-12s in residential care, the reality is very different, and that existing foster care resources are not available in either the number, location or type of placement to make it a reality in the short term. We were concerned that the use of both units was perhaps not as closely monitored in terms of numbers/length of stay as it could have been.

Recommendation 120: The Council should reconsider and clarify its policy on residential care for the under-12s and plan for the provision of appropriate resources.

15.52 Children under 12 who have been deemed for whatever reason to require residential rather than foster placement are children who present particular responsibilities for the department. Many of these children have continued to require long term residential care. They are children with very special needs. The Council has a clear responsibility to provide the highest standards of assessment and provision to address these needs.

15.53 We were unclear as to whether the elected members had a complete knowledge of the problems the department might be experiencing in terms of under-12 provision.

Recommendation 121: We recommend: (a) that a system be established to notify senior management of instances when children are left in short term accommodation for longer than the estimated period, and where no suitable alternative can be identified; and (b) that reports should be produced for elected members, at least on an annual basis, on the incidence of use of residential units for children under 12 and on the problems experienced with regard to provision of suitable resources for that age group.

Recommendation 122: We recommend that the Director of Social Work increase the department's efforts to identify additional emergency/short term foster carers to avoid inappropriate admission to residential care.

15.54 The particular stresses of working in establishments which provide emergency responses should be recognised and appropriate shift/working patterns developed to allow time off and reduce excessive overtime. This may require suitable permanent staffing complement, with access to additional sessional staff as needed.

15.55 We reiterate our Recommendation number 40 with regard to the inappropriateness of applying a performance factor in respect of the care of children.

E. Inappropriate Placements - Main Themes

15.56 Inappropriate placements represent a major threat to the safety of children and young people looked after by the Council. They also place unacceptable burdens upon staff and adversely affect morale.

15.57 We are very aware that many of the issues we have identified in this regard are already known to senior management and that lack of resources lies behind the failure to address them effectively. We consider that our Recommendation 1 above, about a principled corporate approach to supporting more children within their communities, together with a necessary decision by the Council as a whole to exclude residential care from application of the performance factor (Recommendation 40), will go some way to addressing these matters. It will also improve morale in the sense that the young people and children, and those who care for them, will feel that they are “owned” and supported by the Council as a whole and the wider community which it represents.

16. INDEPENDENT PERSONS

A. Introduction

16.1 The possibility of introducing “independent persons” as an added support for looked after children has been referred to at various points in this report:

1. In connection with the role of the social worker in acting as an external link for children in residential or foster care;
2. In connection with involvement in external activities, and the role of befrienders;
3. In the paragraphs setting out the main themes relating to identification and expression of concerns; and
4. In the main themes relating to children with special needs.

16.2 In point three, we referred to significance of the personal relationship as the criterion of an effective safeguard, as distinct from the assignation of a particular role. Children will express their concerns to people they know and trust when they have confidence that they will be able to help. It also important that the children feel that the people they trust also know and trust them. It was noted with regard to the past (Lesson 19) that the victims said that one of the reasons they did not tell about the abuse when it was happening was that they had felt stigmatised by being in care. They did not think the adults around them would believe them. Unfortunately, those who did try to tell often found their fears borne out by experience. A further lesson from the past (Lesson 48) was that children’s chosen confidantes might sometimes be people regarded by the department as difficult or as having other agendas to pursue. We concluded that, while clearly having an obligation to test out reported concerns, the department should be careful to avoid an assumption that the these reports are untrustworthy.

B. The Kent Report Recommendations

16.3 The Kent Report had made various recommendations about the involvement of independent persons:

- The appointment of 15 full time Children’s Advocates throughout Scotland, born of the Children’s Rights Officer service;
- Appointed Persons to visit each establishment along the lines required in England by Regulation 22 of the Children’s Homes Regulations which followed on from the Children Act 1989 (Rec. 43);
- an independent person to hear complaints from children (Rec. 45);
- Every child living away from home without immediate access to a parent should have a befriender or independent person or guardian appointed. This is particularly important for those children for whom the rights and powers of a parent have been assumed by the local authority (Rec. 46);
- The creation of Adjudicators along the lines of the Child and Family Charter of the erstwhile Lothian Region (Rec. 47);
- Extension of the role of the Safeguarders appointed under the Children (Scotland) Act 1995 to include some of safeguarding and advocacy functions discussed in his report.

16.4 In an interview with the Inquiry team, Mr Kent explained that he had taken a “scatter gun” approach to the issues of independent persons. It would not be necessary to implement all of these recommendations, but he hoped that some would find favour.

C. The Barnardo’s Provisions

16.5 We also received information from Barnardo’s about a number of independent persons involved with their own units. These could be classified as:

- Appointed Visitors
- Advocates
- Befrienders
- Volunteers.

a. Appointed Visitors

16.6 These are appointed by Barnardo’s in Scotland to fulfil the role set out in the English guidance referred to by the Kent Report.

16.7 The role is described in Volume 4 of the Children Act 1989 Guidance and Regulations as follows:

Regulation 22 of the Children’s Homes Regulations 1991 requires monthly visits to all homes by those responsible, or by their representatives (not being someone employed at the home). Written reports of such visits are to be made to those responsible for the homes..... An important purpose of these visits is to ensure that the day to day conduct of the home is seen by someone not involved in its operation..... The visits should be unannounced and reports of visits should be seen by the responsible authority without amendment or deletion.....Before each visit, the responsible authority should provide the visitor with copies of reports of visits made in the preceding 6 months. The responsible authority should also provide the visitor with guidance as to the purpose of visiting and the items to be covered. These should always include a check of sanctions imposed on children, the home’s daily log and the physical condition of the premises. But visitors must always be given the opportunity for private conversation with any child, other family member, or staff member who requests it; and should always report on their observation of the children.

16.8 This independent check has the character of a supplement to the inspection process rather than a support for individual children such as would encourage them to express concerns. It offers opportunities for children to speak about safety issues, and some children might indeed do so. However this cannot be assumed.

b. Advocates

16.9 Barnardo's established and launched Partners in Advocacy, a project which provides trained, independent but unpaid persons to help people with learning difficulties have their voices heard. Their task is to help their partners speak for themselves, or to speak for them, whichever is appropriate.

16.10 Advocates are linked with individuals. Some are called in at short notice when a particular issue requires their assistance. Others are linked on an ongoing basis, which allows them to build up a relationship with their partner and to identify possible issues themselves.

16.11 Advocates might, for example, accompany young people to reviews.

c. Befrienders

16.12 These have a less formal role with regard to specific children. They may take them out on treats for example.

d. Volunteers

16.13 These also have a less formal role. The difference between them and the befrienders is that volunteers are attached to a project rather than a child.

16.14 Whilst the Barnardo's provisions relate to persons with learning difficulties, it seems to us that this four-fold categorisation is helpful in separating out the different kinds of function an independent person might perform in the wider care population. Their roles are distinguished according to whether they relate to the individual or the project, and according to the level of formal involvement in the life of a child.

16.15 In practice, of course, there is some overlap. Long term advocates are of particular value because their developing relationship with the child or young person is more likely to encourage the discovery or sharing of concerns. Befrienders, and also some volunteers may in fact develop relationships with residents that are significant in terms of safeguarding the child.

D. Conclusions

16.16 In order to provide an effective safeguard for children and young people living away from home, the crucial factor is that there is *somebody* independent of the unit or carer who is known and trusted by the child and has the potential to respond appropriately to concerns displayed or expressed. There is no point in introducing another stranger into a child's life if the child already has appropriate support. Many people, including young people, expressed concerns to us on this point.

16.17 The child might have a parent, other relative or family friend, teacher, social worker, youth worker, befriender, or a number of other people in her or his circle who could be trusted with any worries about safety.

16.18 Of our consultees, BASW Scottish Committee supported the idea of a relevant befriender as opposed to statutory independent visitor on the basis that children relate to those they feel comfortable with.

16.19 A voluntary organisation indicated that they had experimented with the appointment of an independent visitor in the past when one of their Governors had taken on the role. What happened was that the Visitor came and sat in an empty house for two hours and the young people went out. Young people did not see it as relevant to them and were therefore not interested.

16.20 When assessing the comments of various contributors to this debate, it is essential that the distinction be borne in mind between a person appointed as an independent visitor to *the unit*, with a remit whose character is more that of a supplement to the inspection process (we will refer to this person as the “Appointed Visitor”), and an independent person appointed with the expectation that he or she will be the recipient of concerns expressed by a *child*. We have come to the conclusion, for the reasons outlined above, that introduction of a new independent person to perform the latter function is unrealistic and often unnecessary.

16.21 Therefore, with regard to *the children and young people*, we believe it is important that the admission process includes an identification with them of the adults they would feel confident in approaching with concerns. We understand that new forms currently being piloted for looked after children include space for the identification of significant people in a child’s life. It may be that this could be developed with a specific emphasis on the suitability for receiving the child’s concerns.

16.22 There may be a number of such people. The child should be helped to think through how to contact that person and what difficulties might arise. It may also be appropriate to consider checking out with the adults named their willingness to receive such concerns and act on them, on the understanding that this is not a formal, legal role; and indeed to give them some helpline numbers should they need information.

16.23 Where a child had no suitable persons identified, the social worker should regard it as a priority to introduce the child to a suitable befriender or advocate. The Children’s Rights Officer should take a special interest in the welfare and progress of the child until such a relationship was established.

16.24 With regard to *the unit*, we consider that there could be advantages in identifying Appointed Visitors along the lines of the model introduced for England and Wales by the Children Act 1989. We refer back to the issues raised at Chapter 10 about the independence of ELRIS and the need for more regular, unannounced visits. Given that we have also supported Kent’s recommendation that foster care be brought within the inspection process, which will extend the remit of ELRIS and reduce its capacity to take on other activities, we consider that

the introduction of Appointed Visitors on the 1989 Act model would be a practical and useful development.

Recommendation 123: We recommend that the admission process for looked after children include identification of at least one suitable, independent person to whom the child would feel confident about expressing concerns. The person or persons identified by the child should be made aware of this designation and asked if they would be available and willing to listen to the child. These persons should be informed of ways in which they could progress concerns and should recognise that they are not being asked to take on a formal, legal role with regard to the child if they do not have that role already.

Recommendation 124: Where no suitable independent person is identified, the child's social worker should seek to introduce a befriender or advocate who might gain the child's trust. Until this situation is satisfactorily resolved, the Children's Rights Officer should take a special interest in the child concerned through regular contact.

Recommendation 125: We recommend that Appointed Visitors be identified for each residential unit with a remit modelled on that of the Appointed Visitor under the Children Act 1989. They should be regarded as an extension of the inspection process and should report to ELRIS.

17. INDEPENDENT ORGANISATIONS

A. Role of Local Authorities on Management Bodies

17.1 In our discussion of the past abuse in relation to Dean House, we looked at the role of the local authority representatives on the Board of Governors. It was far from clear what was expected of them. Their appointment to the Board placed them in a situation in which they had legal responsibilities with regard to Dean House in connection with that position of trust. It was not clear how these particular responsibilities correlated with their wider duties as elected members of the local authority.

17.2 It is important to be clear about the reason for appointing elected members to outside bodies, otherwise conflicting understandings and expectations can adversely impact on the welfare and safety of children. If there are expectations that elected members will function as an added safeguard in terms of becoming aware of issues within the organisation and channeling any concerns back to the department, then that should be made clear to them and expectations with regard to attendance at meetings and transmission of information should be clarified.

17.3 In the course of the public hearings, it was indicated that recent guidance had clarified the role of Council representatives on the Boards of Trusts or companies. Separate "Reporting Officer" posts were to be created, in addition to the Trustee, to allow more effective reporting back to the local authority. This scheme was currently being implemented. Regarding the Dean and Cauvin Trust, it was understood that, in addition to an elected Board member, the Council also provided link officers to facilitate communication.

17.4 This still envisages the appointment of elected members as trustees, although balanced by the new reporting officers. In our view there remain difficulties in reconciling the responsibilities of Council member and trustee of an organisation receiving funds from the Council. It would be more appropriate for the elected member, or even for officers of the department, to attend in the capacity as an assessor rather than as a member of the governing body as such, and with the consequent clarity that their responsibility was to the local authority and the children looked after by it, rather than to the independent organisation itself.

<p>Recommendation 126: We recommend that the Council revise its policy on appointments to outside bodies to ensure that elected members have a clarity of remit in connection with the appointment, and are given the guidance and support to enable them to fulfil that charge.</p>

B. Role of Members of Voluntary Management Committees

17.5 It was noted in relation to the past (Lesson 26) that the Dean House Board of Governors and House Committee were said to have "run on good will." There was no clear allocation of responsibility or accountability. The Governors regarded themselves as mainly looking after the financial matters, yet they personally investigated one of the allegations of abuse against a member of staff (Dean House Report 7). The House Committee had no clear remit. There was no clear authority for the setting up of the Committee of Inquiry into the

allegation by Child P and the results were not formally reported back to the Board or the House Committee.

Recommendation 127: We recommend that ELRIS should take particular care to ensure that independent organisations looking after children on behalf of the Council have clarity of responsibility within their organisational structures about matters relevant to their care and protection.

C. Role of Local Authority Link Officers

17.6 Lesson 27 from the past concerned the lack of a clear remit for the local authority's link officer with Dean House.

Recommendation 128: We recommend that local authority link officers with independent organisations caring for looked after children should have a clear remit to enable them to carry out that role.

18. STAFF

A. Staff Morale

18.1 It is a commonplace that the status, training and conditions of employment of staff in residential child care are not good and compare unfavourably with field social workers. It has been argued that this impacts upon the morale of staff and the safety of young people.

18.2 BASW Scottish Committee commented in their written submission:

We would argue that there can be no safe and effective system for the care of young people unless issues around the adequate care of staff are taken fully into account. There is no doubt that social work staff experience a much higher level of workplace stress than individuals working in other professions. Such stress will be a contributory factor both to unacceptable behaviour towards consumers and to willingness to challenge the actions of others. This was evidenced by the recent NISW research "A Workforce in Transition: The Careers and Experiences of Staff in Social Work Departments - 1998." This has been the conclusion of more than one previous inquiry and there continues to be ample evidence of employers ignoring the needs of staff at the cost to the service user.

18.3 The Kent Report concluded:

Staff pay and conditions can have a vital impact on the morale of staff, and thus on the morale of the children and young people in the unit. (Para. 6.3.2)

The need to raise the status and professionalism of the care task simply reflects the fact that children living away from home are often the most vulnerable. Compare the health service: if you are ill you get treated in one way. If you are very ill you get treated in another; you go to special facilities with skilled experts. Children in care, and children who need special boarding schools, must go to centres of excellence with exceptional staff. (Para. 8.15)

18.4 The Skinner Report said :

The staff providing care feel undervalued and ill-equipped, and are not always doing a good job (Conclusion 6.3).

In general, salaries and conditions of service of residential child care staff should be improved in order to attract and retain staff with sufficient ability and qualifications. (Rec. 45)

18.5 These issues have yet to be fully addressed within the child care system nationally. We have ourselves made recommendations with regard to training staff for the task of residential child care and increasing professionalism. In particular, we are concerned that staffing levels should not be subject to "performance factors" associated with budget cuts.

18.6 Good carers are crucial to good care. The following are just two of the comments made to us by staff on this matter:

Staff need to feel valued. Before that, need to feel understood. Top levels are too remote.

We don't get the stroking. We get the kicking. No-one says you did a good job.

18.7 The issue of positive feedback is relevant to the introduction of an appraisal system discussed in Chapter 9.

18.8 The rest of this section of the report sets out some of the comments made to us by staff addressing some specific considerations, which are important in themselves, but which also have an impact on morale. The specific issues highlighted are:

- lack of leadership where no-one is in charge;
- lack of domestic staff;
- issues about night staff;
- staffing difficulties at weekends; and
- lack of administrative support.

B. Lack of Leadership when No-One in Charge

18.9 This was identified as an issue in three of the units. In one, the unit manager was off in connection with training, and no-one was “acting up” in his place. One unit had lost their manager and were sharing one with another unit. In a third unit, there had been no manager for 3.5 years, including one year when the manager had been off sick. No one was “acting up” to the manager’s post. It had been advertised, but there had been difficulties in filling it. At the time of our visit, the Services Provision Manager’s post was also vacant. Staff were feeling isolated and unsupported. One commented: “We only survive because of our trust in and commitment to each other.”

18.10 The lack of clear leadership was demoralising. Whilst we recognise that short term absence due to sickness or for the purposes of training may not require a specific response, we are of the opinion that someone must be appointed to take on a leadership role when the absence is prolonged. We hope that our recommendation about removing the performance factor will help achieve this aim.

<p>Recommendation 129: When a unit manager is absent, there should be clarity about who the staff should look to for leadership, and the person so identified should ensure that he or she has time set aside to take account of that responsibility. Where an absence is expected to extend beyond six weeks, a temporary manager should be appointed.</p>

C. Lack of Domestic Staff

18.11 Problems associated with lack of domestic staff were identified in three units. Balerno, which caters for younger children, had had no regular domestic staff for two years. The effects of this were obvious during our visit. This leads to an environment which is not conducive to high morale amongst children or staff. In addition, involvement in more menial tasks, not directly associated with care, can divert staff from the tasks they were employed to undertake.

18.12 Another unit had had no cook or domestic for a long time. There had been a number of failed attempts to recruit such staff. In the meantime, residential care staff had been

performing these duties. A third unit had had no weekday cook for some time. The young people commented that they did not like the food they were given. This was a source of tension within the unit.

Recommendation 130: We recommend that the Director of Social Work continues to recognise the constructive role that domestic staff can and do provide for children in residential units.

D. Night Staff

18.13 Some concerns were expressed about the safety of residents and staff arising out of the night-time arrangements. The pattern appeared to be that, up to the early hours of the morning, there would be two staff on waking duty. The “twilight” shift would leave at about 1.30a.m. There would remain one waking night staff, with another sleeping over and available if necessary.

18.14 In one unit there was a concern expressed that the sleepover staff in another room might not be easy to contact if a situation arose. A student commented on the fact that young people had “acted up all night” on five or six occasions since he had been in placement. A situation had arisen in which a resident had to go to hospital, accompanied by a staff member, leaving only one staff member on duty.

18.15 A question was raised about the acceptability of a solitary male being on waking night duty, both in terms of the safety of children and the vulnerability of the staff member. A manager from a voluntary organisation, whilst acknowledging the possible vulnerability of the staff member, was of the opinion that the safety of residents was not compromised if sufficient care had been taken in recruitment and training. If the person was not felt to be a safe worker, he should not be working in residential care at all. It was noted in Chapter 9, in connection with gender issues in recruitment that one manager had identified as his greatest concern the fact that he had “an unsophisticated male night staff who were inadequately managed.”

18.16 During the public hearings, the Head of ELRIS assured us that inspectors looked at night staff to see whether they were integrated into the whole staff team, e.g., for meetings, training and involvement in care planning.

E. Staffing Difficulties at Weekends

18.17 A member of staff from the Emergency Social Work Services Team told us that weekend staffing arrangements seemed to involve a high proportion of temporary and inexperienced staff with no-one to turn to for advice. Theoretically, the Director and Head of Operations were available out of hours for consultancy. The Emergency team was available, but was not resourced to go in and take over control of a unit in trouble for example. The Emergency team had responsibilities for Midlothian and East Lothian as well as Edinburgh. Its remit was not restricted to children. In the past years, for example, there had been an increase in the number of mental health cases requiring out of hours attention. The provision of out of hours assistance was identified as “a major problem.”

Recommendation 131: We recommend that the Director of Social Work should recognise the problems arising out of normal office hours and (a) take steps, in conjunction with the Emergency Social Work Services team to ensure access to appropriate management support; and (b) consider identifying experienced Locums who could be on call for particular needs.

F. Lack of Administrative Support

18.18 A senior manager spoke about the lack of administrative support, which had been progressively reduced in response to budget cuts as a more acceptable measure than cutting direct services for young people. He said, this had significantly impacted upon his ability to do his own job. He described himself as “the most highly paid photocopier in the business.”

Recommendation 132: The Director of Social Work should ensure that his department is provided with appropriate clerical and support services to free management to devote their time to appropriate professional duties which include their responsibilities for the safety of children.

19. HISTORICAL ABUSE

A. Introduction

19.1 This inquiry was set up as a result of convictions relating to child abuse which followed on from reports made some considerable time after the abuse itself took place.

19.2 The earlier part of this report shows how some children did try to raise concerns at the time, and how these efforts continued, for a number of years in some cases, before the report which triggered the investigation leading to the convictions.

19.3 In recognition of this, we have made recommendations aimed at alerting Council employees to the implications of concerns about past abuse which might arise out of their contact with adults who have experience of the care system.

B. Recent Case

19.4 A former employee told us of a report she had made to the social work department in 1994 concerning an allegation by a young man with learning difficulties that he had been abused as an adolescent by a member of staff of a voluntary home which had since closed. The former employee's concern was that, on receipt of the allegation, the department had taken no steps to find out the whereabouts and current occupation of the alleged abuser, who might still have been working in childcare.

19.5 It should be noted that, as with the cases of some of the former victims of the abuse leading to the establishment of this Inquiry, the report was initially made to a social work team other than the children and families' team; in this case, the Community Care Team. It would appear that the response at that level was knowledgeable and professional. The blocks to taking the matter forward arose higher up the ladder.

19.6 The former employee raised the matter again with the department in response to the publicity surrounding the High Court case. This resulted in the department appointing two persons to conduct an internal investigation which concluded that a member of staff had failed to follow up the report in an appropriate way. This had been due in part to his departure from the post at a key stage, which had caused some disruption and had been a significant contributory factor in information being lost and tasks remaining incomplete.

19.7 Residual issues identified by the investigating officers included;

- The poor physical shape of case records;
- Dates wrongly stated in records
- Names wrongly recorded;
- Difficulties in identifying the author of Detail Records.

19.8 The investigation report recommended:

- Greater attention to detail in record keeping;
- Clearer guidance in the child protection guidelines with regard to responding to allegations of past abuse; and
- Extending training on responding to such allegations to all sections of the Social Work Department.

19.9 There are striking similarities between the issues underlying this investigation and some of those relating to reports discussed in Chapter 4 in respect of which we have made recommendations. We also have, in common with the investigating officers, encountered difficulties due to inaccurate and difficult to read records. We support the recommendations of the internal inquiry. We are aware that the department is currently drafting guidance on responding to reports of historical abuse. Building on Lessons 37 and 57 from the past, we believe these guidelines should apply to all social workers and residential workers, not just those in child and family teams. We also believe that, when a decision is made not to proceed with investigation of an allegation, the reasons for that should be clearly recorded.

Recommendation 133: We recommend that the guidelines currently being drafted by the Social Work Department with regard to response to allegations of historical abuse should be directed to all social workers, not just those in child and families teams. They should take account of the Lessons from the past set out in this report. In particular, when a decision is made not to proceed with an investigation, the reasons for that decision should be clearly recorded.

C. Responding to Historical Allegations

19.10 Questions have been raised about the propriety of pursuing allegations of past abuse, and the possibility of justice, given that the passage of time inevitably means that memories of events will have been impaired and vital evidence lost. We have encountered these difficulties ourselves in the course of our investigations, where records have been destroyed, in the normal course of events, or were not kept properly in the first place, and where we have sometimes received conflicting accounts of the same event by equally credible witnesses. This was the case for example with regard to the accounts of the letter delivered to staff by one of the victims (described in Chapter 4 as Glenallan Report 1) and the issue of who visited Child G in prison (discussed in Chapter 4 as Glenallan Report 2). These details were not in themselves particularly significant, but they were an important reminder to us that memory can be faulty.

19.11 Nevertheless, we would not wish that acknowledgement to be used to justify a policy of not investigating allegations of historical abuse. As a society, we still struggle with the difficulties involved in helping young victims speak out when the abuse is actually taking place. It is our view that developments over the past decade, involving as they have a painful recognition of the prevalence of abuse and the past reluctance to acknowledge it, have made it easier for children to tell about abuse. Some of our own recommendations are also aimed at helping children tell, or helping adults associated with them identify that abuse might be taking place. However, we cannot be confident that these measures will enable every incident to be identified and every victim to speak out. If we do not help children to tell later on in life, and take their stories seriously, we will be creating “open season” on vulnerable young people

and encouraging abusers in their attempts to silence their victims in the knowledge that the passage of time will prevent the matter from being pursued at a later date.

19.12 One of the victims, asked in court about his response to the abuse at the time it was taking place, replied, "I cried slowly." One, on answering the door to the police and being informed of their general inquiry, immediately gave the name of his abuser, even though he had spoken to no-one of that abuse in the past and had not spoken the person's name for some 20 years. These can be powerful reminders that abuse hurts, that the hurt takes a long time to heal, and that it can also take a long time before victims feel safe enough and confident enough to speak about what happened to them.

20. COSTS OF THE INQUIRY

20.1 Throughout this report we have placed great emphasis on the corporate responsibility of the Council, and the community which it represents, for Edinburgh's children. We believe this should be reflected in the responsibility for the costs of this Inquiry.

<p><u>Recommendation 134:</u> We consider that it would be consistent with the concept of corporate responsibility if the costs of this Inquiry were to be borne by the whole Council rather than charged to the Social Work Department.</p>

21. CONCLUSIONS ON REMIT 2

21.1 Clearly the Council has a great many safeguards in place for children looked after by them. Some are more effective than others and they are not always uniform in their application across the City.

21.2 We have identified within our recommendations a number of adjustments and further safeguards. The next chapter of this report aims to set these out as an agenda for action and to identify some priorities.

22. REMIT 3 – THE FUTURE

A. Text of Remit

22.1 Part 3 of our remit required us:

To make recommendations as appropriate arising from remits 1 and 2 with a view to assuring the Social Work Committee and the public that every measure is in place to minimise child abuse.

B. Planning and Prioritising the Inquiry's Recommendations

a. Action plans

22.2 We have made a large number of recommendations, which are listed in sequence at the end of this report. Having identified a need for the Social Work Department to be clear in its communications with staff about what is expected of them, we feel ourselves under an obligation to attempt a similar clarity. Accordingly, we have grouped together the recommendations and suggested how they might best be allocated to and discharged by particular bodies or officials.

b. The Council

- Acknowledge corporate responsibility for looked after children [1].
- Acknowledge acceptance of risk in care decisions [2].
- Authorise comprehensive care strategy across departments [3].
- Authorise establishment of cross-departmental Task Force [5].
- Exempt residential care from application of the performance factor [40].
- Safeguard field social worker's time with looked after children from application of the performance factor [72].
- Accept the necessity and cost implications of maintaining empty beds [4].
- Agree to apply to Council establishments the registration standards of independent establishments [66].
- Raise at national level the need for a Scotland-wide Children's Commissioner [79].
- Continue and increase efforts to keep looked after children in local schools [93].
- Clarify remit of members appointed to outside bodies [126].
- Charge the costs of the Inquiry to the Council's corporate budget [134].
- Ensure elected members consider how to best inform themselves of issues related to life in residential units for which they have a responsibility [70].
- Ensure that children and young people looked after by the Council have information about elected members and how to contact them [71].

c. The Chief Executive

- Make information on responsibilities relating to children available to workers in all departments [9].
- Seek exemption from equal opportunities provisions regarding specification of gender of residential child care workers [14].
- Set up procedure for "police intelligence" regarding workers/volunteers in all departments to be directed towards the Child Protection Register holder [16].
- Clarify with police and SCRO expectations about receipt of such information [17].
- Ensure that birth certificates for those seeking employment with children are produced and checked before SCRO checks are made, to identify changes of name [18].
- Seek priority for SCRO checks for residential care workers and identification of timescales where there are delays [19].
- Ensure retention of references relating to those working with children [23].
- Provide guidance on provision of references [24, 25].
- Identify children away from home on the Council's authority who are not "looked after" [117].
- Prepare and submit to the Council an annual report on the progress of implementation of the recommendations in this report [135].

d. Director of Social Work

Written Information

- Involve practitioners in production of a policy and practice manual for residential workers [6].
- Review written information for parents and children in residential units [7].

- Ensure children and young people know who to contact when social worker absent [73].
- Ensure information about their child protection responsibilities is given to *all* social workers [8].
- Ensure consistent availability and explanations of complaints procedures [98].
- Give guidance on recording of withdrawn complaints [103].
- Extend “whistle blowing” procedures to bad management [78].
- Amend absconding protocol to clarify involvement of external person [62].
- Ensure guidelines on historical abuse are given to *all* social workers [133].

Communication

- Clarify and rationalise incident forms, etc. [57].
- Provide an “immediate response” space on the significant occurrence form [58].
- Consider simplification of procedures regarding involvement in external activities [97].
- Devise a separate system for communicating positive achievements [60].
- Safeguard time for visits to units by external managers and Directorate [69].
- Ensure reports are made to children’s hearings when children subject to supervision allege abuse [87].
- Where appropriate, inform unit managers of the outcome of complaints emanating from their units [102].
- Ensure appropriate account is taken of insights of foster carers [113].
- Ensure clarity of remit for link officers with independent organisations [128].

Analysis of Information

- Analyse instances of absconding and patterns re particular individuals [61].
- Forward absconding statistics to ELRIS [63].
- Identify ELRIS as the focus of information collation [67].
- Prepare annual report to Social Work and Education Committees re non-attendance at school by looked after children [94].
- Audit availability of private telephones in residential units [100].
- Monitor feedback to young people on complaints and involve an independent person [101].
- Ensure CRO annual report provides more analysis of information and monitors progress [107].
- Monitor, and report annually to elected members, statistics and use of residential care for under-12s [121].
- Monitor use of restraint [56].
- Monitor frequency of social work visits to children in residential or foster care [75].
- Interview staff who resign for other than obvious reasons and monitor unusual resignation patterns [91].

Commissioning

- Ensure extra vigilance regarding “spot purchase” arrangements [11].
- Ensure extra vigilance where the owner of an independent establishment has operational responsibilities for child care [83].

- Ensure complaints by children boarded outwith the city are notified to Edinburgh Complaints Officer [104].
- Ensure funding of aftercare is part of the contractual agreement with independent organisations [89].

Policy

- Require CRO to check young people's experience of SCRO checks on families of friends [20].
- Promote appropriate use of discretion regarding SCRO checks on families of friends [21].
- Seek increased opportunities for looked after children through communication with the Director of Recreation about access to leisure facilities [96].
- Reconsider policy on residential care for under-12s [120].
- Make Recruitment and Development Centre available to independent organisations [12].
- Make Locum Bureau available to independent organisations [43].
- Consult with unions and promote the advantages of probationary periods as opposed to temporary employment contracts [26].
- Raise with COSLA and the Scottish Office the appropriateness of National Standards in relation to young offenders aged 16 –18, and up to age 21 [92].

Recruitment and Development Centre Procedures

- Ensure procedures reflect the spirit of the Warner Report regarding attitudes to sexuality [13].
- Attempt to incorporate young people's views in the selection process [15].
- Adopt consistent procedures to include enquiries about significant time gaps in employment history, interview of both referees, and discretion to approach other previous employers [22].

Locums

- Make the filling in of evaluation forms mandatory [38].
- Ensure Locums are not generally used to cover vacant posts [39].
- Identify as legitimate the practice of units establishing relationships with particular Locums [41].
- Identify gender as an appropriate consideration in allocation of Locums [42].

Training

- Ensure staff are trained to identify behaviour indicative of abuse [27].
- Adopt and promote the long term aim of a fully qualified staff in residential child care [28].
- Until that aim is achieved, establish and require HNC/SVQIII as the minimum qualification [29].
- Ensure all social workers are trained to understand the potential impact on adults of life as a looked after child [90].
- Ensure staff are trained on complaints procedures and their own role regarding them [99].

- Instigate an independent evaluation of CALM; pass the Inquiry's concerns to the Care and Control Group; and raise issues relating to restraint at national level [55].
- Supplement written policy on "whistle blowing" by video material to be viewed and discussed in whole staff groups [80].

Supervision

- Ensure that staff supervision is given a higher priority and that child safety is a standing item on the agenda [33].
- Revise supervision policy to provide for a minimum one hour every four weeks for care workers [31].
- Reconsider the amount of space available for recording supervision on forms [32].
- Identify supervision as one way of facilitating a handover which is relevant to clients' needs when a worker leaves [30].
- Review achievement of supervision targets annually [34].
- Require that, where a contact is identified as supervision, it is recorded as such at the next formal session [35].
- Ensure supervision is distinguished from requests for advice [36].
- Declare supervision notes to be the property of the Council [37].

Support for Staff

- Amend Whistle Blowing policy to identify independent persons [81].
- Ensure that staff expressing concerns about colleagues have support independent of line management [82].
- Make appropriate interim arrangements for leadership when unit manager absent [129].
- Recognise constructive role of domestic staff in residential units [130].

Support for Young People

- Ensure that the admission process identifies at least one independent person who might act as the child's external confidante [123].
- Identify the key worker's role as a co-ordinating one, including assisting in identification of confidante for the child [76].
- Ensure that, where no such person is identified, the social worker introduces a befriender. The CRO should visit the child until an independent person is found [124].
- Ensure that, within 48 hours of admission, the key worker or other designated person researches and presents to staff the child's history and significant care issues [77].
- Ensure that young people involved in allegations against carers are offered the support of the CRO or other independent person [109].
- Ensure that young people with special needs have at least one other person who can communicate with the child and receive the child's confidences [118].
- Amend the 1997 Children and Families Practice Notes/Guidelines to clarify provision of support for the child while an allegation is being investigated [45].
- Indicate that the person giving such support should also ensure the child has support before, during and after judicial proceedings [46].
- Ensure that feedback to young people on the progress and outcomes of investigations is monitored and is not dependent on the way in which the allegation was raised [48].

- In association with the Children's Reporter, advise children and young people of their rights to take a representative to the children's hearing [84].

Social Workers

- Ensure social workers give meetings with looked after young people the same priority as departmental meetings or child care reviews [74].
- Advise field and support social workers to make occasional unannounced visits to foster placements [115].
- Advise support workers to inform foster carers of the substance of this report and the value the Inquiry places on fostering [116].

Investigations, etc.

- Ensure that, when an allegation is made against a carer, the full range of responses set out in the 1997 Guidelines is considered [44].
- Ensure that the recently appointed personnel officer with responsibility for investigation of allegations conducts the actual investigatory role, supported by a practice perspective from social work managers [47].
- Where discretion is exercised to waive the requirement regarding retention of information, ensure that a record of that decision is kept in a secure place outwith the department [49].
- Ensure full implementation of the Finlayson/Newman recommendation regarding involvement of the Child Protection Co-ordinator where looked after children are alleged to have been abused [53].
- Ensure allegations against foster carers are carried out by independent persons [112].
- Establish specialist legal support for disciplinary matters, conversant with the requirements of child protection [51].

Investment

- Appoint at least one more Children's Rights Officer within the Social Work Department [105, 107].
 - Ensure alternative support for adults, by someone other than the CRO, if the needs identified during the High Court proceedings, or allegations of abuse, arise again [108].
 - Seek funding for a full time Who Cares? post [110].
 - Support young people to attend Who Cares? Meetings [111].
 - Develop aftercare as supplement to exit interviews for young people [88].
 - Extend inspection to foster care [114].
 - Invest in the Outworkers and Niddrie Family Resource Centre [119].
 - Identify more emergency/short term carers [122].
 - Set up Appointed Visitors for residential units [125].
 - Ensure appropriate management support outwith business hours [131].
 - Ensure appropriate clerical support for management [132].
- e. Heads of Departments other than the Social Work Department**
- Identify, and offer detailed guidance to, workers whose role has a particular impact on children [10].

- Ensure appropriate source of advice when dealing with disciplinary matters involving the safety of children [52].
 - Review procedures for responding to and investigating abuse allegations involving children [54].
- f. Director of Education**
- Ensure all schools take advantage of whole school training on child protection [95].
 - Help identify children living away from home on the Council’s authority, but not “looked after” [117].
- g. ELRIS (Edinburgh and Lothians Registration and Inspection Service)**
- Negotiate with independent facilities a protocol for reporting significant incidents [59].
 - Negotiate with independent facilities extension to them of the protocol on absconding [64].
 - Continue discussion with Who Cares? Scotland to identify appropriate introduction of young people’s views into inspection [65].
 - Co-ordinate regular four way meetings with CRO, Complaints Officer and Who Cares? [68]
 - Ensure independent facilities have clarity of responsibility with regard to child protection [127].
- h. Children’s Panel Training Organiser**
- Encourage panel members to consider creating opportunities to speak to children outwith the presence of their carers [85].
- i. Chair of the Children’s Panel**
- Continue attempts to obtain a degree of continuity of membership of children’s hearings [86].
- j. Chief Constable**
- Clarify grounds for not proceeding with investigation of allegations of child abuse when the children concerned are or have been in residential care and record reasons for decisions about continuance or discontinuance of such investigations [50].
- k. Duties in Respect of Independent organisations (All replicated elsewhere, as indicated)**
- Make Recruitment and Development Centre available to them [Social Work Policy 12].
 - Make Locum Bureau available to them [Social Work Policy 44]
 - ELRIS to develop protocol for reporting incidents [ELRIS 61]
 - Extension to them of protocol on absconding [ELRIS 66]
 - Ensure clarity of structure and responsibility [ELRIS 129]
 - Ensure extra vigilance regarding “spot purchase” arrangements [Commissioning 11].
 - Ensure extra vigilance where the owner of an independent establishment has operational responsibilities for child care [Commissioning 85].
 - Ensure complaints by children boarded outwith the city are notified to Edinburgh Complaints Officer [Commissioning 106].
 - Ensure funding of aftercare is part of the contractual agreement [Commissioning 91]

C. Implementation

22.3 In the course of our enquiries, the opinion was regularly expressed by consultees that the recommendations of inquiries such as ours tend to have a short lifespan and are often not implemented. Inquiries come and go, but life does not necessarily change. There is little point in spinning out more and more recommendations, many of which might have little hope of realisation due to lack of resources, and many of which may also appear merely to repeat what has gone before. "Implementation not Recommendation!" was the call of one worker who spoke to us.

22.4 We have considerable sympathy with this view. Some of what we have recommended is not new. Much of it is already well known to the department and the workers within it. However, it would be remiss *not* to include such matters when the need is still there. For example, the Council's business plan for 1997/98 set out a number of "inescapable social work priorities," listed as follows:

- Enhance child welfare services to families in their own homes.
- Ensure an adequate volume of residential childcare operating to high adequate material standards and sound professional practice.
- Commission, with Education, residential school places in Edinburgh.
- Recruit foster carers/community placements within the city, particularly for 8-11 year olds.
- Prepare and train staff for the implementation of the Children (Scotland) Act 1995.
- Develop a range of services for children with disabilities and their families.
- Prepare the Children's Services Plan on an inter-agency basis.

22.5 We also invited those who attended the public hearings to submit their own recommendations for the future. Many of these are referred to within the body of our report. The Director of Social Work indicated to us his priority areas for change as:

1. To continue listening to young people. In particular, senior managers must have time freed up to "walk the patch."
2. To continue communicating with staff. There is a continuous management task in restating and reinforcing what is in place.
3. To reduce the volume of written information and make it more accessible.
4. To secure a capital allocation sufficient to introduce a planned maintenance programme for all units and to extend the volume and range of units to enable a choice of units at the point of placement.
5. To ease or remove the performance factor to allow the department to undertake preventive work and speed up the replacement of staff who leave.
6. To achieve a recognition that ordaining that training should occur is not sufficient alone to effect an increase in the number of trained people in post, or the supply of trained people in the employment market.
7. To succeed in implementing the single entry point recruitment plans combined with the assessment centre approach to new entrants to residential child care.
8. To clarify and extend guidance on dealing with allegations of historic abuse; to agree a protocol with the police and fiscal on the investigation of such cases; and to obtain clarification on the basis on which decisions are taken about the extent of police enquiries in such cases.

9. In the absence of a General Social Work Council, to consider how allegations of poor practice are followed up when this comes to light in an agency after the individual has moved to another job.
10. To consider the introduction of a right of appeal on the part of the authority against decisions of managers in disciplinary matters.
11. To check whether looked after children have participated in the “Feeling Yes, Feeling No” programme as a child, and to run an age-appropriate course for those who have not.

22.6 The Purchasing, Planning and Commissioning Manager, (Children & Families) suggested further recommendations:

1. **Foster Care** – More rigorous selection process with risk assessment focus for some aspects of the homestudy. This argues for resource team staff having the Child Protection Certificate. Adequate resource team support to carers and space for workers to do more visits, including unannounced ones.
2. **Care and Control** – Work with young people looked after by the Council to engage their help in working on effective and safer interventions if restraint is needed.
3. **Children who abuse** – Identify staff training needs to help these children – make better links between children and families workers and criminal justice workers to learn from each other and to develop joint strategies to protect children who abuse with diversion and management of their behaviour.
4. **Understanding the Mind and Working Pattern of Adult Abusers** – Necessary for residential child care managers to be able to intervene if there is suspicion of staff acting inappropriately.
5. **Staffing Levels** – The critical importance of a well-staffed unit needs continually to be restated. If there are gaps in rotas, locums at short notice, safeguarding children becomes considerable more difficult.

22.7 Accordingly, we feel it might be helpful at this point were we to set out what we think we are saying that is new in itself or on which we are placing a new or higher emphasis than other reports, and what we believe the priorities for implementation should be.

D. What are we saying that is significant in the light of what has been said before?

a. Corporate Responsibility must become a reality.

22.8 The notion of the “corporate responsibility” of the local authority is not a new one. It is a central principle of the Children (Scotland) Act 1995. The challenge is to turn the concept into reality. There needs to be a genuine ownership of responsibility by the Council’s elected members and chief officials across all departments.

b. Application of a “Performance Factor” is inappropriate.

22.9 Neither is the concern about application of the performance factor a new issue within the Department. Indeed it featured prominently in the Director of Social Work’s written submission to us. However we believe it needs a specific emphasis within the philosophy of local authority services. The United Nations Convention on the Rights of the Child requires local authorities to regard the welfare of children as a primary consideration in *all* matters that concern them. This applies also to the allocation of resources. Children looked after by the Council cannot be regarded as another budget heading to which savings can be applied. As indicated at 9.179 above, if parents were in financial difficulties and had to cut

their expenditure, our society and our courts would expect them to retain their care for their children as their highest priority. Where that society has taken the serious step of removing children from their families or taking over their care on the basis that to do so is in the welfare of the children, it must accept its responsibility to accord the care of those children at least the same level of priority when it has to make difficult decisions about resources.

c. All Social Work department staff must be made aware of their responsibilities with regard to children.

22.10 Social workers working specifically with children and families are not the only ones who need to know about children. Criminal justice social workers have a crucial role to play; as have those working in community care.

d. The values underpinning anti-discriminatory practice should be extended to responses to disclosure of abuse.

22.11 Social work values clearly advocate anti-discriminatory practice, yet it seems that responses to reports of abuse (some admittedly going back a number of years) have been coloured by speculation about the motivation for telling of people who are experienced as difficult or who may be suspected of trying to divert attention from their own offending behaviour and somehow reduce assessment of their personal responsibility for wrong-doing. Whilst assessment of credibility is an element within the legal process, there needs to be a conscious check upon such assumptions about motivation.

e. There is a need to reinforce and support the exercise of discretion within procedures.

22.12 Procedures in themselves, while necessary, do not protect children. They must be applied with mature, informed and confident judgement, involving an acknowledgement of uncertainty and an element of risk. Social workers need the professional training, status and support to enable them to carry out those tasks and to maintain the confidence and support of the public in whose name they act.

f. Bad management can facilitate abuse or be a screen for it.

22.13 In all of the units we have addressed with regard to past abuse, bad management was the focus of concern at the time rather than abuse. For this reason we have recommended that concerns about management should also fall within the scope of the “whistle-blowing” procedures.

g. Residents and Staff might both resort to “behaviour” when unable to articulate their concerns.

22.14 Clearly one cannot assume that name-calling such as “Perv” is evidence of abuse. However, it is important to be sensitive to this and other behaviour of residents, as well as behaviour by staff which might be reflected for example in unusual patterns of resignations, even if they appear to be explained on an individual basis.

h. Difficulties caused by people leaving or changing their employment.

22.15 It is essential to the welfare of children that procedures are introduced to ensure that, when a worker moves on or a case is transferred, all relevant case notes, reports and a transfer summary are included in the case file.

i. Individual responses to having been abused as a child.

22.16 It has become clear to us, from what those involved in the trial have told us, that people have different methods of coping with memories of childhood abuse. Some said that, as a survival tactic, they had tried to put it out of their minds and get on with their lives. Nevertheless, when the police arrived on their doorsteps in connection with their inquiry into these residential units, they knew immediately what it was about and the memories came flooding back. Others responded in a different way and have tried many times over the years to tell about what happened to them. For many, it was a relief to be able to tell about the abuse when they eventually had a suitable opportunity to do so.

j. There is a need for guidelines on responding to allegations of historic abuse.

22.17 This is generally acknowledged within the Social Work Directorate, but not as yet generally within the Department. The guidelines should balance the need to take matters forward, given the continued threat the alleged perpetrators might pose to children, with a need to avoid precipitate action which might cause a retraction of the allegation or which might be experienced by a vulnerable complainer as harassment. In the police investigation leading to the High Court case, the victims appreciated the fact that the police moved “at their pace.” However, it is also significant that the police did not give up when victims showed signs of initial reluctance or hesitation. They maintained supportive contact without intrusion or harassment.

k. Concern about the past should not be allowed to divert concern from the present.

22.18 Allegations of historic abuse require a serious, thoughtful and concerned response. As indicated in Chapter 19, they should not be disregarded merely because of the passage of time. Nevertheless, events that took place a long time ago are difficult to establish because memories fade, records are lost and the people involved die or move away. Hopefully, our greater awareness today of the reality of child abuse and the need to respond promptly to allegations will mean that, as time goes by, the incidence of historic allegations will decrease. Meantime, we are still working through the legacy of the past and do not know whether the emergence of such allegations has yet peaked. While it is important to investigate such allegations, both for reasons of justice and to ensure that those who pose a risk to children’s safety are identified and restrained from working with them, it is also very important to ensure that the energy and resources devoted to exploring the past do not divert our attention from the very real needs of vulnerable children today.

E. Priorities for Implementation

22.19 We would identify the following as the priority areas for implementation of our recommendations:

- Engendering corporate responsibility
- Removal of the performance factor
- Submission of local authority units to registration
- Supervision, appraisal and training
- Policy and provision with regard to under-12s
- Appointment of an additional Children's Rights Officer
- Funding of a full-time Who Cares? post
- The need for every child to have an external confidante
- Video training on whistle-blowing, plus identification of an independent person within the process
- Addressing the isolation and vulnerability of foster children and those with special needs.

F. Monitoring

22.20 As indicated above, experience has shown that when the immediate impact of Inquiries has passed, there is a possibility that accepted proposals for the development of good practice can be ignored or reduced in importance by the advent of some other major work pressure or departmental or other structural change. We therefore recommend that the Council call for an annual report from the Chief Executive on the implementation progress of those recommendations within our report which they accept. In that way, they would demonstrate to the public at large, and in particular, children who may be looked after by them away from their own homes, as well as their families, that the Council continues to place a high priority on the safety of all such children. Further, they would demonstrate to those who had been abused in the past that they recognised that future children should not be subjected to such experiences as was suffered by them.

Recommendation 135: The Council should receive an annual report from the Chief Executive on the progress of implementation of the recommendations of this report.

G. Minimising Child Abuse - How assured can we be?

22.21 Our remit requires us "to assure Social Work Committee and the public that every measure is in place to minimise child abuse."

22.22 The word "minimise" is well chosen. It would be impossible to set up a system so tight that the possibility of abuse was altogether excluded. Any attempt to achieve this unattainable aim would result in disappointment, recrimination, a defensive attitude by staff which would be unhelpful for children, and the imposition of restrictions on children themselves which would be inimical to healthy development.

22.23 That said, this does not absolve us from the responsibility of making sure that children are as safe as they can be. A two-pronged approach is required. The child care system must be so organised as to provide the safest possible environment for children. In particular, staff recruitment and supervision must be rigorous and consistent. Children and young people must also be helped to identify and articulate concerns with the assurance that they will be taken seriously and progressed sensitively.

22.24 The City of Edinburgh's introduction of the Recruitment and Development Centre for Residential Child Care is a very significant development. Our recommendations about supervision and appraisal are designed to ensure that protection from inappropriate staff behaviour is extended throughout the period of staff employment. It is also important that staff currently in post who no longer meet the requirements for the increasingly demanding tasks of residential child care, should be helped to move out of that work.

22.25 The City of Edinburgh has also been forward thinking in its appointment of a Children's Rights Officer. Our recommendations are designed to build on this strength and develop the role. In particular, it is essential that foster children, those with special needs, and those living away from home on the authority of the Council who do not fall into the definition of "looked after" should be brought into contact with this officer. Our recommendations are also designed to ensure that every child has at least one independent confidant outwith his or her living situation, with the Children's Rights Officer filling in any gaps until a suitable person can be introduced to, and win the trust of, any child who does not have one.

22.26 Clearly, there are resource issues involved in implementation of our recommendations. Although it is the Social Work Committee our remit requires us to reassure, a major theme of our work has been the responsibility of the whole Council for Edinburgh's children. We are confident that, if the Council as a whole harnesses its resources in support of Edinburgh's children, then that assurance can reasonably be given.

23. REFERENCES

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24. GLOSSARY

- APO: Assistant Principal Officer
- BASW: British Association of Social Workers
- CRO: Children's Rights Officer
- CSS: Certificate of Social Studies
- CSU: Close Support Unit
- ELRIS: Edinburgh and Lothians Inspection and Registration Service
- FRC: Family Resource Centre
- Field worker: a social worker who works in the community but retains a responsibility for children in residential or foster care
- PO: Principal Officer
- Performance factor: a reduction in actual monies available to employ staff expressed as a percentage of the budget
- RCO: Residential Care Officer. Now a basic grade post, but formerly the name of a post with responsibilities for external management
- SCRO: Scottish Criminal Records Office
- YPC: Young People's Centre – a residential facility for young people

25. LIST OF RECOMMENDATIONS

Recommendation 1: The Council as a whole should explicitly acknowledge its corporate responsibility for children looked after by them and its determination to ensure that this is fully reflected in policy formulation and practice.

Recommendation 2: The Council should publicly acknowledge their acceptance that there are risks involved both in keeping children in the community and in looking after them, and should ensure that its professional staff feel supported in implementing decisions arising from risk assessments.

Recommendation 3: The Council, through the Chief Executive, should devise a comprehensive care strategy which recognises residential care as part of a continuum. It should draw on the expertise of all departments of the Council and should include a clear strategy for community based support for children and young people in order to avoid inappropriate use of residential resources. Residential care must be used and available where it is a positive choice for young people.

Recommendation 4: Provision of residential units must be at such a level as to allow a genuine choice of placements to best meet the needs of young people. In implementing this recommendation, the Council must accept that this will require units to operate at times at less than maximum capacity.

Recommendation 5: In pursuit of Recommendation 3, the Council, through the Chief Executive, should set up a high level task force drawn from all of the departments and agencies which would be involved in the preparation of Children's Services Plans with a remit to devise a corporate strategy for more community based support for children and families, drawing on the resources of all relevant departments. The conclusions of the task force should help shape future Children's Services Plans. In particular, the task force should: (a) produce a plan for requiring a child impact analysis to be attached to all policy developments or practice changes proposed by the Council; and (b) ensure that their new initiatives, replacing the former Youth Strategy, incorporate the need to identify immediate school placements for all looked after children.

Recommendation 6: The Director of Social Work should review the policy and practice guidance issued to staff by providing an easily understood manual for residential workers. In particular: (a) practitioners should be involved in advising on the presentation of that manual and such subsequent materials as are produced; (b) action points should be identified on policy and practice material so that there is no doubt about how recipients are expected to respond; and (c) policy and practice information, and in particular new information, should be discussed in team meetings and in the following supervision sessions and backed up by training where appropriate.

Recommendation 7: The Director of Social Work should review the written information residential units give to children and parents on admission, with a view to ensuring a consistent high standard. The section on safety should include information for young people about what to do if they feel unsafe. The department should set a timescale for this task and ensure that resources are available to produce good quality booklets that young people will look at and keep for reference. Key workers and field workers should ensure that young people looked after by the Council have received and understood the booklet's contents.

Recommendation 8: The Director of Social Work should ensure that all social workers, not just those in children and families' teams, are given readable and relevant information about how child welfare and child protection concerns impact on their own responsibilities.

Recommendation 9: The Chief Executive should ensure that workers in all Council departments are given a simple, strong, persistent message which inculcates in them the habit of taking account of the welfare of children. Information should be provided about the Council's policy and contact points for staff if they want more information or have concerns.

Recommendation 10: Heads of Departments should consult with the Director of Social Work to identify employees whose work is likely to have a particular impact upon children with a view to offering them more detailed guidance on ensuring that the interests of children are given a high priority.

Recommendation 11: Where a spot purchase arrangement is entered into for residential child care, the Director of Social Work should ensure that extra vigilance is applied to identify and act upon any concerns about standards of care for the child. Appointed Visitors (see Recommendation 125 below) would be an important additional safeguard, as would visits from the Children's Rights Officer and the Who Cares? worker.

Recommendation 12: The Director of Social Work should consider making the facilities of the Recruitment and Development Centre for Residential Child Care available to those independent agencies caring for children looked after by the City of Edinburgh.

Recommendation 13: The Director of Social Work should ensure that the procedures set up by the new Recruitment and Development Centre for Residential Child Care continue to reflect the spirit of the Warner recommendations on attitudes to sexuality, with a particular focus on the identification of inclinations towards paedophilia.

Recommendation 14: The Council, through the Chief Executive, should continue endeavours designed to obtain exemption from equal opportunities requirements to allow an appropriate gender balance on the staff of residential child care facilities. If this is held not to be possible within the terms of current law or policy, the matter should be raised at national level.

Recommendation 15: The Director of Social Work should consider how to incorporate and develop the use of feedback from young people with experience of care in the selection processes set up by the Recruitment and Development Centre for Residential Child Care.

Recommendation 16: The Chief Executive should set up a procedure whereby, apart from responses to requests from departments for SCRO checks, "police intelligence" about Council employees or volunteers with substantial access to children should be directed towards the Child Protection Register holder, whatever Council department is involved.

Recommendation 17: The Council, through the Chief Executive, should consult with the police and SCRO to clarify the expectations of all parties in giving or receiving such information. Council staff should recognise that a "not on record" response from SCRO is not a positive indication of suitability.

Recommendation 18: The Council, through the Chief Executive, should ensure that successful applicants should be required to disclose any former names and to produce their birth certificates before checks are carried out.

Recommendation 19: The Chief Executive should, through the Chief Constable, initiate an approach to SCRO to seek agreement (a) that checks for prospective residential care workers should be given priority; and (b) if the request cannot be responded to within one week, that an interim response should be made to explain that there will be a delay, together with an indication of the likely timescale.

Recommendation 20: The Director of Social Work should ask the Children's Rights Officer to check with a sample of young people their experience of SCRO checks on friends in connection with overnight stays in order to ascertain whether the situation described by some young people to the Inquiry is general or particular to specific Units, and whether the issue continues to be a real concern for young people.

Recommendation 21: The Director of Social Work should ensure that SCRO checks on the friends of young people are not carried out routinely in order to protect the department or individual members of staff. There should be encouragement and support for workers to exercise the discretion and to use the fast track procedure described at the public hearings.

Recommendation 22: The Director of Social Work should ensure that the recruitment processes for the Recruitment and Development Centre for Residential Child Care should (a) involve seeking explanations for significant time gaps in employment history; (b) routinely involve interviewing both referees; (c) indicate that the Centre retains discretion to approach previous employers who have not been named as referees, and make it clear to applicants that this is a possibility.

Recommendation 23: The Council, through the Chief Executive, should ensure that references for those working with children are retained in the employee's personnel file.

Recommendation 24: The Council, through the Chief Executive, should give guidance to employees on the provision of references, indicating who is authorised to provide them and the extent of inquiry before a reference is written. Employees providing references in a personal capacity should be required to make it clear that it is personal and should not write the reference on Council notepaper.

Recommendation 25: The Guidance referred to at Recommendation 24, should state that members of staff should not give references for clients which omit any mention of the nature of their relationship, even if that is now in the past.

Recommendation 26: The Council, through the Director of Social Work, should discuss with the unions whether the existence of a proper probationary period in the context of a permanent contract, as opposed to a temporary period of employment, does not offer greater protection both for the employee and for the children and young people in residential care.

Recommendation 27: The Director of Social Work should ensure that the training programme for residential and field work staff is designed to assist them to respond appropriately to behaviour by children which might be an indicator of abuse.

Recommendation 28: The Council should aim to have a fully qualified professional staff in residential child care. We recognise that this is not achievable in the short term, and that consultations are ongoing about what the appropriate qualification should be. The Government's Response to the Kent Report has addressed this issue as well as the implications for staff who remain unqualified.

Recommendation 29: Until the aim set out in Recommendation 28 is achieved, the HNC/SVQIII should be the minimum acceptable qualification. Staff with no qualifications should be given all appropriate opportunities and support to ensure that this qualification is obtained.

Recommendation 30: The Director of Social Work should ensure that, as soon as a worker intimates that he will be leaving his or her post, supervision sessions should have a particular focus on the steps he or she is taking to ensure that matters are left in a satisfactory state to

facilitate an easy handover. The supervisor should ensure that key tasks are identified and that the worker has sufficient time to carry these out.

Recommendation 31: The Director of Social Work should revise the department's policy on supervision to require a minimum of one hour every four weeks for residential child care workers. If a session is cancelled it should be rearranged. Every worker should receive at least 12 supervision sessions each year.

Recommendation 32: The Director of Social Work should reconsider the format of the form for recording supervision in terms of the space available for information to be inserted.

Recommendation 33: The Director of Social Work should ensure that supervision is placed much higher on the list of priorities for residential child care staff. Child safety should, as Kent suggested, be a standing item on the supervision agenda.

Recommendation 34: The Director of Social Work should ensure that achievement of supervision targets is reviewed annually by unit managers and the results considered in the context of the manager's appraisal.

Recommendation 35: We recommend that, where a contact between members of staff is identified as supervision, it should be recorded at the next formal supervision session.

Recommendation 36: Supervision should be distinguished from requests by staff for opinions, advice and guidance from their seniors. A requirement to record such requests could inappropriately discourage staff from asking for advice or responding to such requests.

Recommendation 37: Supervision notes should be declared to be the property of the Council, and should be maintained within the Unit. They should be transferred to the staff member's personnel file when he or she leaves the Unit.

Recommendation 38: We recommend that the filling in of evaluation forms be deemed mandatory in relation to the first five shifts of new Locums and for all Locums when serious concerns have been experienced about them.

Recommendation 39: We recommend that Locums should not be used to cover vacant posts, other than to provide immediate cover until a short term/temporary contract can be arranged.

Recommendation 40: It is our clear view that it is unacceptable to compromise the safety of children by requiring that some posts remain unfilled in order to cut costs. We therefore recommend to the Council, in the strongest terms, that residential child care units be exempted from the application of the performance factor in relation to staffing.

Recommendation 41: Recognising the advantages for units of building relationships with particular Locums, we recommend that this should be recognised as a legitimate and appropriate use of Locum Bureau staff.

Recommendation 42: In particular, we recommend that the Locum Bureau managers respond as positively as possible to requests by units for a Locum of a specific gender where this is relevant to achieving an appropriate gender balance in the unit or otherwise addressing an issue of safety.

Recommendation 43: We recommend that specified voluntary organisations be given access to the Locum Bureau.

Recommendation 44: The Council should recognise that the safety of children in residential units is dependent upon them being cared for by an able, confident, secure staff team; that suspension of any staff member can adversely affect children's security; that consideration should always be given to the possibility of alternative employment for the staff member during the period of investigation; and that every effort should be made to complete the investigation at the earliest possible date. We therefore recommend that the full range of managerial responses to allegations of abuse set out in the 1997 Children and Families Practice Notes/Guidelines be explored and utilised where appropriate. The reasons for the decision to choose one response rather than another need to be clearly articulated and recorded.

Recommendation 45: We recommend that the 1997 Children and Families Practice Notes/Guidelines be amended to set out the clear expectation that the task of ensuring that the child's interests are safeguarded includes the provision of appropriate support for the child. This may well be appropriate for the child's own social worker, but there should be a discussion with the child about who the child feels happy to accept such support from, and considerable weight should be given to those views in identifying the source of support. The child must always be given the option of independent support.

Recommendation 46: Notwithstanding the welcome development of programmes to support child witnesses within court settings, we recommend that the individual identified to provide support in accordance with Recommendation 45, should also ensure that the child has appropriate support before, during and after judicial proceedings.

Recommendation 47: We welcome the recent efforts of the Department to train its managers in investigation and to relieve some of the burden upon them by the appointment of a personnel officer with a responsibility for investigation. We recommend that the allocation of roles between the manager and the personnel officer should be such as to recognise that the manager's main function is to contribute the perspective of contemporary practice, while the personnel officer carries the brunt of the investigatory tasks. Rather than an investigation by a social work manager with consultancy from a personnel officer, these roles should be reversed. We further recommend that this matter should be kept under review to ensure that managers are not diverted from their main responsibilities.

Recommendation 48: We recommend that provision of feedback to children and young people, and the form it takes, should not be dependant upon the way in which the allegation arose. We reiterate the recommendations of the Finlayson/Newman Report in this respect and suggest monitoring of satisfaction levels of young people regarding feedback on allegations, no matter the procedure through which they are processed.

Recommendation 49: We consider that it is appropriate that the 1997 Children and Families Practice Notes/ Guidelines allows the Director of Social Work to waive the requirements regarding retention of information when he is satisfied that the allegation has no substance, We recommend that a record is maintained of the Director's decision and the basis for it, in a secure, separate location outwith the Social Work Department.

Recommendation 50: We believe there should be greater clarity about the grounds for a decision by the police to investigate or not. The reasons for police decisions should be recorded so that future investigations which may be connected can test their significance.

Recommendation 51: We recommend that the Department put in place a source of legal support for disciplinary matters which is fully conversant with the requirements of employment legislation and child protection and aware of the need to keep child protection as the highest priority.

Recommendation 52: We recommend that the Heads of other Council departments consider how they deal with disciplinary cases involving the safety of children and take advice on formulating procedures to address this.

Recommendation 53: We recommend that the Finlayson/Newman recommendation about involvement of the Child Protection Co-ordinator in consideration of allegations of abuse of looked after children be fully implemented in order to ensure a more independent element in the consideration of the case. This includes allegations relating to children in foster care.

Recommendation 54: We recommend that Heads of Departments other than social work, and specifically the departments of education and recreation, review their own procedures for responding to and investigating allegations in the light of the recommendations of our report.

Recommendation 55: With regard to the CALM training on care and control, we recommend: (a) an independent evaluation which includes taking account of the experiences of young people and staff who have expressed concerns as to the nature and relevance of that training; (b) that the Inquiry's concerns be transmitted to the Care and Control Group currently convened by the department; and (c) that the Director of Social Work raise at national level the need to devise a training programme for care and control which takes advantage of the best aspects of those training packages currently available.

Recommendation 56: We recommend that there be central monitoring of the frequency of restraint with explanations sought for variations amongst Units.

Recommendation 57: We recommend that the purpose of the incident, violent incident and significant occurrence forms be clarified, and rationalised if appropriate. There should be an identifiable purpose for recording of incidents involving young people in order to avoid any unnecessary intrusion on their privacy.

Recommendation 58: We recommend that a space on the significant occurrence form should allow staff to indicate whether they regard the issue as one requiring an immediate response. They should be required to justify this claim. Where such a space has been used, an immediate response should be given.

Recommendation 59: We recommend that the Head of ELRIS enter into negotiations with independent facilities providing residential care for the city's children to devise a protocol for reporting significant incidents.

Recommendation 60: We recommend that the Director of Social Work consider devising a separate procedure for communicating positive achievements within residential units.

Recommendation 61: Whilst we acknowledge that the recently introduced protocol on responses to absconding calls for a careful exploration of reasons for any reluctance to return, and also for a review of patterns of absences from the unit, we recommend that staff and field workers should endeavour to analyse every incident of absconding and the reasons therefor, and pay particular heed to any patterns emerging from repeated absconding with regard to individual young people.

Recommendation 62: The wording of the protocol on absconding should be amended to clarify matters relating to the involvement of an external person to talk to an absconder. It would be appropriate for all such young people to be offered the opportunity to speak to the Children's Rights Officer, Who Cares? or another independent person.

Recommendation 63: Statistics on absconding, relating both to the young person and the unit should be forwarded to the Registration and Inspection Unit for analysis. The experience of the Emergency Social Work Services Team in this connection should be taken into account.

Recommendation 64: The protocol on absconding should be extended to independent units.

Recommendation 65: We recommend that the Head of ELRIS continue discussion with Who Cares? Scotland to identify the most appropriate way of introducing into the inspection process the perspective of those with experience of the care system.

Recommendation 66: We recommend that the Council exact the same standards of their own residential resources as they expect of independent establishments in respect of registration and de-registration, and accept the same implications if an establishment is assessed as falling below those standards.

Recommendation 67: We recommend that ELRIS be identified as a focal point for the collection and analysis of information relating to local authority units in the same way as currently happens with independent units, with regard to child protection issues, investigations and disciplinary actions, serious incidents of absconding, and formal complaints about health and safety issues.

Recommendation 68: Regular four-way meetings between ELRIS, the Children's Rights Officer, the Complaints Officer and Who Cares? Scotland should be developed for the purpose of sharing insights and information, identifying needs for further information, and facilitating an informed approach to policy development with regard to safeguarding children.

Recommendation 69: The Director of Social Work should ensure that Service Provision Managers have sufficient time clearly allocated for visiting units to carry out their monitoring and supportive role. Other senior Directorate staff should recognise the value to be gained from their individual visits.

Recommendation 70: Elected members should consider how best to inform themselves of issues related to life in residential units for which they have responsibility. This could include meetings with young people and the possibility of visits to units. The Children's Rights Officer should be available to help discuss how this might be achieved.

Recommendation 71: We recommend that information about elected members and how to contact them should be made available to children and young people who are looked after by the Council. Staff should help them make appropriate contact.

Recommendation 72: In line with Recommendation 40, we recommend to the Council that the critical importance of the safety of children requires that any application of the performance factor to field social work should recognise the importance of time spent by them in discharging their duties to children in residential and foster care.

Recommendation 73: The Director of Social Work should ensure that children and young people are made aware of who to contact if their field social worker is unavailable. In cases of long term absence, another social worker should be allocated.

Recommendation 74: We recommend that social workers be required to give the same priority to meetings with young people in residential or foster care as they do to departmental meetings or child care reviews.

Recommendation 75: We recommend that the frequency of visits by social workers to children in residential or foster care be monitored. This should form part of the information

collated for analysis by ELRIS and shared with the Children's Rights Officer. Patterns and changes of patterns of visiting should be identified for the purposes of resource management and policy development, and to help identify any particular child who was not receiving appropriate external support and those who might benefit from a visit by the Children's Rights Officer.

Recommendation 76: We recommend that the key worker system be retained, but that there be official acknowledgement that one cannot rely on the person exercising this role acting effectively as the internal safeguard for the child. The key worker's role should be seen as largely a co-ordinating one, with a specific responsibility for ensuring that the child or young person has a suitable confidante.

Recommendation 77: We recommend that departmental guidance be amended to provide that, within 48 hours of admission of a child or young person into residential care, the key worker, or some other member of staff delegated by the Unit manager, examine the totality of the child's case with the field worker with a view to making an early presentation to unit staff on the child's history and the significant care issues raised by it.

Recommendation 78: We recommend that the "Whistle Blowing" policy be amended to encourage staff also to raise concerns about bad management or other practices which could jeopardise the welfare of residents.

Recommendation 79: The Council should consider raising at national level the need for a Children's Commissioner or Child Welfare Commission with a Scotland-wide remit.

Recommendation 80: We recommend that the Department supplement its written policy on whistle-blowing with use of Barnardo's "Sounding the Alarm" video, or something similar to it, and that this should be shown and discussed in whole staff groups.

Recommendation 81: We recommend that the Free Expressions of Concern (whistle-blowing) policy be amended to include an identified individual outwith social work line management to whom staff have the option of taking concerns. Consideration should be given to ELRIS (Edinburgh and Lothians Inspection and Registration Service) taking on this role.

Recommendation 82: We recommend that support independent of line management is provided for any staff member raising a concern about a colleague.

Recommendation 83: We recommend special vigilance with regard to safety issues when a child is placed in an establishment where the owner has operational responsibilities for child care.

Recommendation 84: Increased efforts should be made to inform young people that they can invite a representative of *their* choice to the children's hearing, and to encourage them to do so.

Recommendation 85: Children's panel members should consider creating opportunities to speak to children outwith the presence of their carers. Their training should include awareness of past incidents of abuse while children were in residential or foster care and the difficulties these children have experienced in telling of such incidents.

Recommendation 86: Continuing consideration should be given to attempts to obtain a degree of continuity of panel membership at review hearings.

Recommendation 87: Where any child who is the subject of a supervision requirement has made allegations of abuse of any kind during their time in residential or foster care, the fact

that that allegation has been made, even if subsequently withdrawn or found by the department to be without foundation, should be included in the review information which is provided for the panel members at the next children's hearing.

Recommendation 88: We adopt the Kent recommendation number 55, concerning exit interviews, to the extent that it would be helpful for staff and the Social Work Department to have the benefit of the young person's reflection on their period in care. However, we consider that this should be the start of an ongoing process. We recommend that the Department develop a supportive aftercare package and the opportunity to continue with trusted relationships, not just because they represent an appropriate discharge of responsibilities, but because this kind of approach is more likely to help young people tell about any abusive experiences.

Recommendation 89: Independent units should not be exempted from providing an element of through care to help young people move on. We recommend that that this be clearly discussed and identified in the planning process and that funding arrangements take account of this requirement which should form part of the contractual agreement between the Council and the independent unit.

Recommendation 90: Further to Recommendation 8 above, we recommend that all social workers, but particularly those in criminal justice teams, be trained and supported to help them understand how the experience of life in residential or foster care can have a lasting impact on young people. In particular, they need to be aware of the possibility that such experiences have not been positive; to be receptive to hearing and taking seriously reports about this; and to be clear about their responsibilities in taking further action on the reports where appropriate.

Recommendation 91: Residential care staff who resign, except for obvious reasons such as moving away from the area or for promotion, should be interviewed by external managers to ascertain the reasons for their resignation. In particular, any unusual patterns of staff resignations should be closely considered. Such interviews would provide an admirable opportunity for external managers to be advised of any concerns that staff members have in relation to general care and safety issues for residents. Such interviews would also provide a basis for responding to subsequent enquiries which may be made of external managers to provide references for future employment which may well impact on the safety of other children.

Recommendation 92: The Director of Social Work should raise with his professional association, COSLA and the Social Work Services Group whether it might be possible to revise National Standards for social workers in criminal justice teams with specific reference to appropriate amendment in relation to young offenders between 16 and 18, or possibly to age 21.

Recommendation 93: We recommend that the Council continues to develop and increase joint initiatives aimed at keeping more children within their local schools.

Recommendation 94: We recommend that the Director of Social Work should collate the following information with a view to its being reported on an annual basis to the Social Work and Education Committees: (a) the number of children who have no school allocated; (b) the number who persistently refuse to attend; (c) the number "not expected to attend" because of an informal understanding; and (d) the number of children who are excluded.

Recommendation 95: We recommend that all schools take advantage of the whole school training on child protection, and that there be an annual refresher course for all education staff as part of in-service training. We also recommend that significant non-teaching staff such as auxiliaries and janitors be included in the training.

Recommendation 96: We recommend that the Director of Social Work enter into discussion with the Department of Recreation to identify ways in which the Council's corporate commitment to looked after young people could be expressed through increased access to leisure facilities.

Recommendation 97: We recommend that the Director of Social Work consider whether the procedures surrounding involvement in external activities are too bureaucratic and whether they could be simplified.

Recommendation 98: We recommend, with regard to complaints procedures that: (a) consistency be sought in ensuring that complaints forms are accessible without the need for asking staff; (b) residents and their parents should be given clear explanations of the existence of the complaints procedure and how to use it as part of their introduction to the Unit; (c) special consideration should be given to younger children and those with special needs, and, as far as possible, age-appropriate written information should be available for them; and (d) the department should ensure that all foster carers and foster children know how to use the complaints procedure.

Recommendation 99: We recommend that staff be trained in the use of complaints procedures and their own role in supporting young people to use the system properly.

Recommendation 100: We adopt Skinner's recommendation number 9 about the need for young people to be able to make and receive private telephone calls. This can be achieved in a variety of ways, through the use of phone cards, for public call boxes or phones appropriately sited within the unit, and the use of cordless phones. All Units need to adopt the good practice that is already happening in some Units. We recommend that the Director of Social Work audit the situation within units and take appropriate action where units do not comply with the Skinner recommendation.

Recommendation 101: We recommend that satisfaction levels about feedback on complaints be monitored and that the department seek to ensure more consistency in feedback, possibly through an independent person.

Recommendation 102: We recognise that some complaints should remain private to the young person, but we recommend the department give further thought to ensuring that, where appropriate, relevant information about the outcome of a complaint is passed to the unit manager.

Recommendation 103: We recommend that complaints procedures make it clear that withdrawn complaints should be kept on record in the unit for scrutiny by external managers.

Recommendation 104: We recommend that any complaints made by children looked after by the City of Edinburgh but boarded outwith the city, be notified to the City of Edinburgh Complaints Officer for information and action if appropriate. This applies also to complaints subsequently withdrawn.

Recommendation 105: At least one more Children's Rights Officer should be appointed. The expansion in staff should be linked with a commitment to making more contact with foster children and those with special needs.

Recommendation 106: No change should be made to the location of the Children's Rights Officers within the Social Work Department.

Recommendation 107: The Annual Report of the Children's Rights Officer to the Social Work Committee should contain more analysis of issues raised with her, as well as a progress report on issues identified in the previous year's report.

Recommendation 108: We recommend that, if a situation such as the High Court case were to arise again, someone other than the Children's Rights Officer should be appointed for the adult support role, or else additional cover should be provided in the office of the Children's Rights Officer to ensure that children and young people are not put at risk by the lack of availability of the CRO.

Recommendation 109: We also recommend that young people involved in allegations of abuse by a carer should routinely be offered the support of the Children's Rights Officer or other independent person.

Recommendation 110: The Director of Social Work should recognise that a full time Who Cares? post is warranted for the City of Edinburgh, given the numbers of young people in residential or foster care, and should seek to identify funding for this.

Recommendation 111: The Director of Social Work should allocate resources to enable Edinburgh children to attend relevant meetings of the Who Cares? organisation.

Recommendation 112: We recommend that investigations into allegations against foster carers be carried out by an independent person with no responsibilities for foster care provision in the area.

Recommendation 113: We recommend that the Director of Social Work evaluate current practice with regard to response to concerns expressed by foster carers about children and young people they have looked after, with a view to ensuring that this takes appropriate account of the valuable insights they may be able to contribute with regard to the welfare of those children.

Recommendation 114: We endorse Kent's proposal that foster care be brought within the inspection process. All foster care placements should be inspected. We recognise this may need to be phased in.

Recommendation 115: We recommend that field and support social workers should make occasional unannounced visits to foster placements.

Recommendation 116: We recommend that, with a view to diluting concerns they may experience by implied suggestions that they are under suspicion, support workers should take the opportunity to inform foster carers of the substance of this report so far as it relates to fostering, including the observations that the Inquiry has made about the value of and need for fostering, and its recognition of the importance of their receiving high standards of relevant training and support.

Recommendation 117: We recommend that the Council take steps to identify those children living away from home on the authority of the Council, for example for educational reasons, who do not have the inbuilt safeguards afforded to "looked after" children, with a view to ensuring that, as far as possible, the same safeguards are extended to them.

Recommendation 118: Where children and young people with special needs live away from home, the Director of Social Work should ensure that, in addition to those caring directly for the child or young person, there is at least one other person who is a regular visitor to the child and who can earn the child's confidence and communicate with the child so far as the child's disability allows.

Recommendation 119: The Social Work Department's review of the functioning of the Outworkers project and the Niddrie Family Resource Centre should be brought to a speedy conclusion, with a clear statement on the future of the units. This should clarify the functions and objectives of the units, ensure that a suitable staffing complement is available, with the correct mix of skills and experience needed for dealing with the age range identified for the units. This review should (a) take account of the Inquiry team's concerns about the physical location of the present buildings; (b) take steps to clarify the external management of these facilities, in order to achieve a consistent approach to authorising placements; and (c) ensure that information about the Children's Rights Officer and Who Cares? is provided as a matter of course within these facilities.

Recommendation 120: The Council should reconsider and clarify its policy on residential care for the under-12s and plan for the provision of appropriate resources.

Recommendation 121: We recommend: (a) that a system be established to notify senior management of instances when children are left in short term accommodation for longer than the estimated period, and where no suitable alternative can be identified; and (b) that reports should be produced for elected members, at least on an annual basis, on the incidence of use of residential units for children under 12 and on the problems experienced with regard to provision of suitable resources for that age group.

Recommendation 122: We recommend that the Director of Social Work increase the department's efforts to identify additional emergency/short term foster carers to avoid inappropriate admission to residential care.

Recommendation 123: We recommend that the admission process for looked after children include identification of at least one suitable, independent person to whom the child would feel confident about expressing concerns. The person or persons identified by the child should be made aware of this designation and asked if they would be available and willing to listen to the child. These persons should be informed of ways in which they could progress concerns and should recognise that they are not being asked to take on a formal, legal role with regard to the child if they do not have that role already.

Recommendation 124: Where no suitable independent person is identified, the child's social worker should seek to introduce a befriender or advocate who might gain the child's trust. Until this situation is satisfactorily resolved, the Children's Rights Officer should take a special interest in the child concerned through regular contact.

Recommendation 125: We recommend that Appointed Visitors be identified for each residential unit with a remit modelled on that of the Appointed Visitor under the Children Act 1989. They should be regarded as an extension of the inspection process and should report to ELRIS.

Recommendation 126: We recommend that the Council revise its policy on appointments to outside bodies to ensure that elected members have a clarity of remit in connection with the appointment, and are given the guidance and support to enable them to fulfil that charge.

Recommendation 127: We recommend that ELRIS should take particular care to ensure that independent organisations looking after children on behalf of the Council have clarity of responsibility within their organisational structures about matters relevant to their care and protection.

Recommendation 128: We recommend that local authority link officers with independent organisations caring for looked after children should have a clear remit to enable them to carry out that role.

Recommendation 129: When a unit manager is absent, there should be clarity about who the staff should look to for leadership, and the person so identified should ensure that he or she has time set aside to take account of that responsibility. Where an absence is expected to extend beyond six weeks, a temporary manager should be appointed.

Recommendation 130: We recommend that the Director of Social Work continues to recognise the constructive role that domestic staff can and do provide for children in residential units.

Recommendation 131: We recommend that the Director of Social Work should recognise the problems arising out of normal office hours and (a) take steps, in conjunction with the Emergency Social Work Services team to ensure access to appropriate management support; and (b) consider identifying experienced Locums who could be on call for particular needs.

Recommendation 132: The Director of Social Work should ensure that his department is provided with appropriate clerical and support services to free management to devote their time to appropriate professional duties which include their responsibilities for the safety of children.

Recommendation 133: We recommend that the guidelines currently being drafted by the Social Work Department with regard to response to allegations of historical abuse should be directed to all social workers, not just those in child and families teams. They should take account of the Lessons from the past set out in this report. In particular, when a decision is made not to proceed with an investigation, the reasons for that decision should be clearly recorded.

Recommendation 134: We consider that it would be consistent with the concept of corporate responsibility if the costs of this Inquiry were to be borne by the whole Council rather than charged to the Social Work Department.

Recommendation 135: The Council should receive an annual report from the Chief Executive on the progress of implementation of the recommendations of this report.

APPENDIX 1: BIOGRAPHICAL DETAILS OF INQUIRY TEAM

Kathleen Marshall (Chair)

- Qualified as a solicitor in 1975 and worked initially in local government in Glasgow.
- 1989 – 1994 Director of the Scottish Child Law Centre (a charity providing advice, information and training on matters relating to Scottish child law).
- Currently a consultant on child law and Visiting Professor at the Centre for the Child & Society, University of Glasgow.
- Author of:

Guidelines on Child Protection for Independent Schools in Scotland; funded by the Scottish Office and published by the Scottish Council of Independent Schools;

Children's Rights in the Balance: The Participation-Protection Debate; published by The Stationery Office in 1997; and

Law and Child Protection (co-author); a distance learning course provided by the University of Dundee.

Cathy Jamieson

- Principal Officer of Who Cares? Scotland since 1992. Who Cares? is a campaigning and advocacy organisation for young people with experience of care.
- Qualified in social work at Glasgow University. Has worked in a variety of settings with young people, including social work area teams and community work, and managed an alternative to care project prior to joining Who Cares? Also involved with youth work on a voluntary basis and has served on the national council of a voluntary children's organisation.
- With young people from Who Cares?, was actively involved in the consultation processes around the Children (Scotland) Act 1995 and the Children's Safeguards Review.

Alan Finlayson

- Solicitor in private practice until 1970.
- Reporter to the Children's Panel, City of Edinburgh and subsequently Lothian Region, 1970-1990.
- Child Law Consultant 1990-Date
- Commissioned by the Scottish Office to write report on the future of Reporters to the Children's Panel in relation to the Children (Scotland) Act 1995
- Commissioned by Director of Social Work, Lothian, along with former colleague to look into other incidents of abuse, Culminating in the "Finlayson-Newman Report": Listen – Take Seriously What They Say (1993)
- Temporary Sheriff 1992-Date.

APPENDIX 2: INFORMATION ABOUT INTERVIEWS AND VISITS

Former Residents of the Three Children's Homes

Of the 27 children named on the indictment, we interviewed 13 directly and one indirectly. We had no contact with the remaining 13.

We interviewed a further three former residents associated with the abuse, and two other children in respect of different allegations.

This was a total of 19 interviews.

Former Staff and Management of the Homes

(Some still work for the authority or for Dean House)

We interviewed:

- 35 local authority staff
- 3 Dean House staff
- 4 Dean House Governors

15 other former staff members were contacted by phone or letter.

Other Professionals

We interviewed four other professionals from the police, the Crown Office and a voluntary organisation.

Parents

We interviewed one parent expressing concerns about a child and were in contact with several others by telephone or letter.

Elected Members

1 elected member who served on the Dean House Board was communicated with by letter and telephone.

Office Visits

We visited the Crown office to see the productions held in connection with judicial processes, and the office of the Company Secretary of the Dean and Cauvin Trust to examine Board and House Committee minutes.

Visits to Residential Units

We visited 16 residential units run by the local authority and five independent establishments. During these visits we spoke with staff and residents.

Foster Carers

We visited 3 foster families in their homes.

SUMMARY

66 interviews

16 other contacts

2 office visits

21 residential unit visits

3 foster family visits

Public Hearings, 1 – 5 June, 1998

We interviewed 27 witnesses

Social Work Department

1. Les McEwan, Director of Social Work
2. Duncan McAuley, Head of Operations
3. Anne Black, Planning, Purchasing and Commissioning Manager (Children and Families)
4. Sue Brace, Head of Planning, Purchasing and Commissioning
5. Ronnie Hills, Head of ELRIS (Edinburgh and Lothians Registration and Inspection Service)
6. John Robertson, Personnel Services Manager
7. Jenny Quinlan, Training and Employee Development Manager
8. Liz Allen, Client Relations and Complaints Officer
9. Dorothy Hill, Business and Communications Manager
10. Linda McCracken, Children's Rights Officer

Who Cares? Scotland

11. David McKuur, Young Persons Worker, Edinburgh, Lothians and Borders
12. Robin McLean, Board Member

Education Department

13. Glenn Rodger, Special Schools and Integration Manager
14. Martin Vallely, Professional Services Manager

Police

15. Detective Superintendent John McGowan
16. Detective Sergeant Jackie Conway, Sexual Offences Support Unit

Dean and Cauvin Trust

17. Lord Osborne, Chair of the Board of Governors
18. Caroline Chittelburgh, Social Work Manager

City of Edinburgh Council

19. Councillor Susan Dalgetty, Deputy Leader
20. Councillor Brian Cavanagh, Convenor, Social Work Committee
21. Tom Aitchison, Chief Executive

Unison

22. J Stevenson, Branch Vice-Convenor
23. J Mulgrew, Branch Service Conditions Officer
24. B McAlister, Regional Officer

Children's Hearing System

25. Kate Lessels, Chairman, Edinburgh Children's Panel
26. Malcolm Schaeffer, Reporter manager
27. Helen Petrie, Authority Reporter.

APPENDIX 3: DIRECTOR OF SOCIAL WORK'S WRITTEN SUBMISSION TO THE INQUIRY

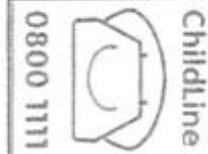
Note that the appendices referred to within this submission were supplied to the Inquiry Team but are not reproduced here.

Note to Media: contact Ken Smart, Media Manager, on 0131 529 4452 for more information.

APPENDIX 4: LEAFLET DISTRIBUTED TO YOUNG PEOPLE PRIOR TO VISITS

This was originally printed on yellow paper.

If you are a young person and you need further advice, you might want to talk to one of the following organisations:

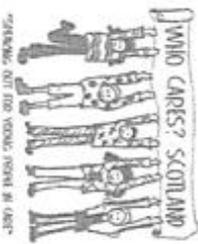


0800 1111
for under 18's to talk about
personal problems

Scottish Child Law Centre



0800 317 500
Advice on the law and
your rights



0141 554 4452
Information and support for
young people with
experience of care

The Edinburgh Inquiry - into Abuse and Protection of Children in Care

We know that some children in care between 1973 and 1987 were the victims of abuse. These issues were raised at the recent trial of two former care workers.

How safe is care?

We need to know if you feel safe when you are being 'looked after' by the council.

As part of the inquiry we are visiting all the residential units in Edinburgh and giving young people 'looked after' by the council the chance to talk to us if they want to.

What we want you to tell us about

-  What would help you feel safe in care?
-  What would help you talk about things which make you feel unsafe?
-  Would you know where to go if anything goes wrong?