

Edinburgh's Children

Summary Report

The Edinburgh Inquiry into Abuse and Protection of Children in Care

Kathleen Marshall, Cathy Jamieson and Alan Finlayson

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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.

Note:

This is a selective summary of a much larger report, which should be referred to for detail of our investigations and conclusions. It is provided to allow those with a general interest to gain some idea of what the report addresses, and those with very specific interests to identify those parts of the full report which might be relevant to their own needs.

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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 set up an Inquiry. Three members were appointed to the Inquiry team: Kathleen Marshall (Chair), Cathy Jamieson and Alan Finlayson. Kathleen Marshall is a lawyer specialising in child law. Cathy Jamieson is Principal Officer of Who Cares? Scotland, and Alan Finlayson is a temporary Sheriff and former Reporter to the Children's Panel for Lothian Region.

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 This summary sets out the complete Foreword from the main report, but an abbreviated description of our methodology and the principles on which it was based. It also omits a large section on “Life in Care” which reflects many of the observations made to us by former residents.

1.4 The descriptions of reports from the past are abbreviated but set out the most significant aspects of our conclusions. Chapter 4 on “Intervening Events” addresses issues raised by receipt of an anonymous letter which extended our remit. This is also abbreviated.

1.5 The main report contains a list of 80 “Lessons” from the past which are gathered together from issues identified within the text. The broad sense of these Lessons is summarised in the section of Chapter 3 entitled “Summary of Themes Arising from the Past.”

1.6 Chapter 5 on current safeguards omits all of the detail and sets out only the introduction to the issues and the main themes arising from them. The fuller report reflects, and sometimes quotes, observations of residents and staff as well as setting out the results of our analysis of papers presented to us. The recommendations at the end of this summary report will give some idea of the matters more fully addressed within the main report.

1.7 Chapter 6 “The Future” is replicated in its entirety from the equivalent chapter in the main report.

D. The Principles on Which we Operated

1.8 Criminal courts are concerned with convicting and punishing wrong-doers. Because of that they have to operate very strict rules of evidence. Our job as an Inquiry had more to do with the protection of children. It seemed to us that this was more like the task of the children’s hearing than the criminal courts. Children’s hearing processes do not have to follow the same strict rules applying to criminal courts. They work on a more informal basis, encouraging children and families to speak openly and honestly with them. We decided that we would also take a more informal approach to our Inquiry. This meant that we did not have to restrict ourselves to the charges on which the accused had been found guilty. We could look wider than that at the experiences the former residents of the homes had to describe to us.

2. REMIT 1 – THE PAST

A. How information was gathered

2.1 We spoke directly with 13 of the former residents named in the indictment. One former resident was in contact with us through a professional currently associated with him. In addition, we spoke with three other former residents not named on the indictment. We interviewed 35 former members of staff of the local authority, three of Dean House, and four current or former Governors of Dean House. 15 other former staff members were contacted by telephone or letter. We were in contact with one elected member of the local authority who had served on the Dean House Board.

2.2 We visited and interviewed one of the convicted abusers (Gordon Knott) in prison. We did not interview the other abuser (Brian McLennan) because he had never admitted any wrong-doing and he had an appeal pending.

B. The facts of the High Court case

2.3 Knott and McLennan had been 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. After the appeal, his sentence was reduced to six years. Knott was also found guilty of possession of indecent photographs.

2.4 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.

2.5 A third accused, Michael Cull, was acquitted of two charges relating to crimes alleged at Dean House. Both cases were found "not proven."

2.6 A fourth person (a woman) was initially subject to two charges. These were dropped because of difficulties arising from witnesses' attendance and their illness.

2.7 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 evidence that they worked together or were part of a "paedophile ring."

C. Life in Care 1973 – 1987

2.8 We thought it was important to find out what life in care was like during the period when the abuse took place, and why it was able to go on for so long without being detected. We asked former residents and staff about this. The main Inquiry report paints a picture of life in care within these units, as described to us by former residents and staff.

3. RESPONSES TO REPORTS BY VICTIMS

A. Introduction

3.1 Our remit required us to find out whether any allegations had been raised prior to the commencement of the police investigation and 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 decide whether the response at the time was appropriate.

3.2 This chapter sets out the “reports” and “behaviours” which we have investigated.

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

3.3 Child J was abused by McLennan at Clerwood. Press reports indicated that she had made a report to a member of staff, but had not gone into detail about the allegations. She has said that the member of staff had not believed her. She did not come forward to speak to the Inquiry, so we were unable to find out any more about this report.

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

3.4 Child D claimed that Child C had tried to tell someone that he had been abused by Knott but had not been believed. Child C could not remember trying to tell. There was insufficient information to pursue this matter further.

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

3.5 In June, 1993, Child B gave a statement to the police implicating a former care worker at Clerwood whom she named as “Alan.” There was a limited police and social work response, focusing on the identity of “Alan.” The inquiry was discontinued when there was a failure to identify him.

3.6 The question is whether enough was done in response to Child B’s allegation when it was made in 1993. We have concluded that greater effort could have been made to have further meetings with Child B who by then was an adult with children of her own.

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

3.7 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.

3.8 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

3.9 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.

3.10 We were unable to find any further information or hospital records relating to this allegation, and are therefore unable to reach any conclusion.

G. Clerwood Behaviour 1 - Children called McLennan a “Perv.”

3.11 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 stated her view 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.

3.12 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.

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

3.13 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. She could not remember how explicit it was. 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 the officer in charge of having taken it. The officer in charge did have a copy of the poem and eventually produced it to us. He denies having stolen it. The poem said:

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.

3.14 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.

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

3.15 Child E told us that children regularly ran away from Clerwood, 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.

3.16 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.

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

3.17 In mid 1979, Child G, who was acknowledged to have been Knott’s favourite, wrote, together with Child K, a note addressed to Mrs Knott, accusing her husband of interfering with G. There was an investigation about which we have been given different accounts. What is clear is that the identities of the authors became known. The outcome was that Child G was persuaded to withdraw his allegation. He said the abuse started again that night.

3.18 According to Knott, the note was left in the unit’s log book where it was accessible to external managers. Knott said no-one ever asked him whether what had been alleged was true. The former Mrs Knott told us that she was involved in speaking to G about the note as she had previously worked with him.

3.19 Both the former Mrs Knott and the former senior manager confirmed to us that the matter had been reported to external management. Three different people were identified to us as having been the external Adviser at the time, who would have been the link between the unit and more senior management. The departmental records could not confirm who held that post at that time. According to the former senior manager, the response of those outwith the unit was determined by the fact that, to their knowledge, the note had remained anonymous. He himself had contacted the police and had been advised that they would not take any action in these circumstances. We were advised by the police that no record would now exist of that kind of telephone conversation.

3.20 Although there are various accounts of what happened, it is clear that an allegation was reported to staff. Given the length of time that has elapsed since the note was written, it is understandable that memories may be faulty. Some of the discrepancies are irrelevant for our purposes, others are more significant. In particular, it seems that someone was not telling the truth about the fact that the identity of the authors of the note was known. 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.

3.21 The action taken was inappropriate in other ways. The child was interviewed by Knott's wife (after other staff had spoken to him). This was clearly inappropriate, even in the culture which obtained in 1979. 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.

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

3.22 Child G told us that, on 14 October 1992, he reported his abuse by Knott to a social worker from the criminal justice team whom he was meeting in connection with the preparation of a social enquiry report for a forthcoming court appearance.

3.23 The accounts given by G and the social work staff show significant differences. According to G and his wife, after that initial reporting, nothing happened, although G later recalled a visit by someone from the department during the course of his subsequent imprisonment.

3.24 The Social Work Department maintain that G's allegation was taken seriously. There were a number of communications. G was also invited to a meeting, which he failed to attend. On that day there was in existence a warrant for his apprehension. Very soon after he was sentenced to three months imprisonment. Social work records note the imprisonment and conclude with the letters "NFA."

3.25 The Client Services Manager states that he wrote to G after his imprisonment and advised him that he should notify the police of his allegations. G and his wife deny that any such letter was ever received. The Social Work Department could not trace the copy letter.

3.26 The departmental view at time was that G himself should be left to take the initiative to get back in touch or take the matter forward. They had 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 also had concerns 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.

3.27 Even if the Department did write to G advising him to take matters forward with the police, we believe that would have been by itself an insufficient response. They should have ensured that he had received the letter and suggested that they accompany him to the police in regard to the allegation to ensure that the matter was properly investigated. Had G declined to go to the police, the Department should have referred the matter to the police themselves.

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

3.28 Child H had been encouraged in his late teens by his social worker to write his life story as part of therapy for himself. What he wrote described his time in Glenallan and referred briefly to abuse by Knott. The book was lodged in court to demonstrate that he had given this account of abuse long before the police enquiry which led to the trial.

3.29 H told us that none of the social workers who had known about the book had actually read it. The book was not in itself therefore a “report made.” However he also said that, when he was 18 or 19, he had met one of his former social workers by chance, had gone for coffee with her and had told her about being abused at Glenallan.

3.30 The social worker confirmed that he had told her that he had been abused. We have concluded that this was certainly a report made, but that it was only one of a confused number of issues about which he spoke. We make no criticism of the social worker in respect of her actions which included counselling him to be clear about what he was saying and that, if the allegation was true, to take appropriate action. We do however take this situation into account later in our report when we consider the response of workers to allegations of abuse.

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

3.31 Two former residents told us that three members of staff had resigned simultaneously in an attempt to draw attention to concerns about Knott. Two of the three staff members confirmed this, but indicated that their concerns had been about poor management rather than abuse.

3.32 Neither Knott nor the external managers to whom we spoke recalled resignations being presented in such a way, in terms of manner or mass, as to raise questions. Had three resigned at one time for no apparent reason, they believed it would and should have invited some investigation. Evidence suggests that there may in fact only have been two actual resignations.

3.33 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, and that management must make appropriate enquiries as to the reasons for resignations.

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

3.34 Child M is said to have reported abuse and been questioned at a police station. She did not accept our invitation to speak to us. Neither Board Members nor staff of Dean House at that time could remember such an incident being reported to them. 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.

3.35 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.

3.36 N was nine years old when she reported to her mother that she had been abused by McLennan. Her mother reported the matter to staff and the police were called. Police sources accept that an investigation took place, but could give no information from records held by them as to the nature and extent of the inquiry.

3.37 McLennan denies the abuse. He has attributed N’s allegation to the instigation of her mother who had a grudge against the home. The key worker said that she too had at that time believed that the child had been set up by her mother to make a false allegation.

3.38 N’s social worker also knew the parents to be inveterate complainers and did not believe the allegation. He could not recall having discussed the allegation with N. He reported it to his superiors, but no further investigation was made by the department. The allegation was not reported to the children’s hearing.

3.39 An examination by a consultant physician at the Department of Genito-Urinary Medicine at the Edinburgh Royal Infirmary 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.

3.40 The Governors recalled the parents of N as persons who were difficult. They had not believed that the officer in charge could have acted in the way that had been alleged. McLennan’s offer of resignation was refused. The investigation was restricted to that of the police and the medical examination. McLennan was not suspended while it took place.

3.41 N impressed us with her account of events at that time. We have no adverse comment to make about the actions of the Governors. The matter had been reported to the police. In the culture of the time, the conclusion of the police investigation and the lack of medical evidence would have been regarded as sufficient reason to conclude their own inquiry. There were cogent reasons for N’s social worker speaking to her about the allegation. Even if the allegation were untrue, it showed that the child was suffering some distress. The investigation itself must have been a difficult experience for her. The allegation should have been reported to the children’s hearing. The medical examination should have been carried out by a police surgeon.

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

3.42 N told the Inquiry that she met her former key worker again in a hostel in which she was resident in 1993. N said to her, “You didn’t believe me when I told you about Brian.” The staff member recalled N having said this, and believed that she may have agreed with her that she had not believed the allegation. She had not discussed the matter fully with N then 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 regarding this.”

3.43 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.

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

3.44 N told the Inquiry that in 1993 she told her probation officer about the abuse. The probation officer had since died. On being advised of the allegation, the probation officer had contacted N's former field social worker from her time at Dean House who did discuss it with 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.

3.45 It would have been appropriate for the social worker to have discussed his responsibilities and potential action with his line managers. We are conscious, as we were in relation to the former key worker referred to in Dean House Report 3, that he knew that the matter had been investigated by the police and apparently concluded. It is understandable why in these circumstances, he did not feel obliged to attempt to mount a further investigation years after the event.

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

3.46 Child O 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 night 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.

3.47 The night workers agreed that Child O had told of her abuse by McLennan. They were clear that O had told them that the matter had been investigated and took no further action personally, other than advising O's key worker of the matter. They would have expected the allegation to have been discussed at a team meeting. In fact, no allegation about O had been made to the police, but they had been notified of allegations by her sisters.

3.48 O's key worker at that time has since died. The officer in charge recalled Child O as one of the residents but had no recollection of an allegation having been brought to his attention. If it had been, he was clear that it would have been recorded in the unit log. We have been unable to obtain sight of these papers.

3.49 A report was clearly made to two night workers. Their understanding was that the allegation had previously been investigated and the matter concluded. The night workers acted appropriately in informing the key worker. The Social Work Department, through their officers, were given an opportunity in this situation to investigate the allegation made by

Child O, but for various reasons did not take that opportunity. There were no guidelines at the time about how reports of historical abuse should be dealt with.

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

3.50 In 1995, Child O, then aged 20, told her probation officer that she had been abused by McLennan at Dean House. He made a clear reference to the abuse in his subsequent report to the court in connection with a further offence committed by O.

3.51 The case resulted in a further probation order. O had earlier moved to another area and her probation was transferred to a different social work office. Her original probation officer communicated with workers in the new area regarding transfer of the order. He then moved to a new job. We have been unable to trace him and understand that he now lives abroad.

3.52 The criminal justice team in the new area knew that there had been some abuse in O's past, but did not know that it had taken place while she was in care. None of them ever saw the report to the court which set out the details. The files held by the criminal justice team did not include information about O's background. This information was held in the Children and Family files.

3.53 An issue arose during the second probation period about abuse of O by a male relative who she said now had access to other children. O was not willing to report this matter formally. She was supported by the second probation officer to encourage this person to remove himself from the home of the children. The criminal justice workers retrieved the file of the male relative who was himself under supervision at the time. We were advised that it was the considered opinion of all staff that there were no child protection issues, although the discussions and assessments about these matters were not recorded, a matter which is now regretted by the staff.

3.54 The action by the criminal justice staff was inappropriate in respect of the failure of the originating team to transfer appropriate information about the case and the failure of the receiving team to insist on reading the report which led to the making of the probation order.

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

3.55 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. His report to staff of abuse by Cull led to an internal investigation in the form of a Committee of Inquiry at Dean House. This involved the Chair and Vice-Chair of the Board of Governors (both eminent lawyers), the officer in charge (Brian McLennan, against whom at that time he had made no allegation) and, representing the local authority, the child's social worker and the Assistant Principal Officer, Residential and Child Care.

3.56 The investigation involved interviewing Child P in the Boardroom. The Committee concluded that, while they did not believe Child P was lying, he might have misinterpreted what was in effect an example of horseplay. 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.

3.57 Copies of the report were sent to those local authority representatives in attendance at the meeting in the Board Room as well as to the Divisional Officer with responsibility for field work.

3.58 P's social worker, who had reported the matter appropriately to her superiors, now believes she "suspended belief" in regard to the child's allegations. This was common in relation to allegations by children at that time.

3.59 Child protection guidelines in force at the time would have indicated that the police should be involved where there were reasonable grounds to suspect that an offence had been committed. The Board representatives were of the opinion that there was insufficient evidence to pass the matter to the police and that to do so would have been heavy-handed.

3.60 Their actions were also influenced by their responsibility as employers to ensure fairness as regards the interests of their employee, and awareness of the need to be able to justify their decision at an industrial tribunal.

3.61 We have concluded that, 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. Nevertheless, even in 1982, improvements could have been made.

1. It would have been preferable if the Committee of Inquiry had interviewed the child in a less formal setting than the Boardroom.
2. Inquiry could have been made of other children and other members of staff, and the member of staff suspended the allegation was investigated. 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.
3. The allegation should have been reported to appropriate senior personnel in the Social Work Department.
4. A record should have been made of the decision to monitor Cull and how it was to be carried out. When McLennan's successor was appointed in 1988 she was given no information as to the allegation having been made or the need to monitor Cull who was still at that time a staff member.

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

3.62 Child 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.

3.63 His attendance at a special school, which had shorter hours than other schools, meant 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 indicated that the abuse by McLennan took place at night after he went to bed.

3.64 Child 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."

3.65 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 this with the staff at the school. His account to us does exemplify the need for school 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.

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

3.66 Q told a trainee psychologist that he had been abused by Cull. The matter was immediately reported to the police. Q was interviewed by a police officer and gave a detailed account of abuse by both Cull and McLennan. The police officer reported the matter to CID and the case was allocated to a Detective Constable.

3.67 Q and his "appropriate adult" were concerned that nothing appeared to have happened. Police information indicates that, on enquiring about progress, the appropriate adult was told by the Detective Constable 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.

3.68 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. It emerged that the Detective Constable, who had received statements from the police officer, had left them in his locker and had failed to continue the inquiries. He may have made some minimal enquiries at Dean House which failed to disclose the identities of "Mick" or "Brian" which were the names given by Q. We understand that the police have disciplined the Detective Constable and taken steps to address the failure of his supervising officer to ensure that the allocated case had been progressed.

3.69 We have concluded that the police response was inappropriate in respect of: the failure of the Detective Constable to continue the enquiries; the failure of his supervising officer to ensure that the enquiries had been carried out; and the failure to communicate with the management of Dean House or the Social Work Department about the allegation.

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

3.70 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 about McLennan's management abilities, his drinking whilst on duty, and the staff's inability to communicate their concerns to the Governors. Meetings between the Governors and senior social work staff

in May, 1987, resulted in the Governors asking the department to conduct an independent investigation into staff relationships and problems of communication at Dean House. The investigation was carried out by two local authority employees: the Principal Officer for Children and the Assistant Principal Officer who was the local authority's link with the home. It involved interviewing all staff, but only one resident. The report was presented in August, 1987.

3.71 The report identified problems associated with McLennan's use of alcohol. The Governors were advised as to the Department's Code of Guidance to assist staff who had problems relating to alcohol. McLennan was said to lack judgement as well as relevant professional abilities and qualifications for the post. There was a general lack of staff supervision and an unsatisfactory rota system which resulted in McLennan filling in gaps. Other concerns related to administration, employment procedures and communication with the Governors.

3.72 As a result, McLennan undertook to enrol for a CSS (Certificate of Social Studies) course. A subsequent incident involving absence from duty without permission led to his being suspended on full pay until the beginning of January 1988 when he was due to commence the course.

3.73 The local authority was then in communication with the Governors regarding their attitude to McLennan's registration as a "fit person" to run the establishment. The Director of Social Work was to report on this matter to the relevant committee on 10 December. On 24 November, McLennan resigned.

3.74 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. On 16 July, 1987, the Assistant Principal Officer who was at that time assisting in the preparation of the report referred to above, furnished a written reference for McLennan to a care organisation for "mentally handicapped people" in Leicester. This was written on Lothian Regional Council notepaper. We have seen the reference and it contained no adverse comment on McLennan's abilities. We believe that the issuing of what the author must have known to be an incomplete and misleading reference was irresponsible and inappropriate.

3.75 After McLennan's resignation, a reference was provided by then Chairman of the Board in response to a request from a prospective employer. She has indicated that it gave an honest and fair account of the applicant according to her experience. We have been unable to trace a copy of that reference and are therefore unable to draw any conclusions about it.

3.76 Social Work Committee minutes confirm that no reports of abuse of children in residential care were reported to the Committee. We make no adverse comment on this. Individual allegations would rightly be regarded as professional issues. The Committee's role is more directed towards general safety. Dean House Report 10 was appropriately reported to the Chair of the Social Work Committee as it was a matter which would have come before the Committee with reference to the registration of that facility and the fitness of the person in charge of it.

3.77 Despite the fact that Board minutes show that representatives of the authority were present at a meeting of the Board of Governors when the conclusion of the investigation regarding Child N was reported, they have indicated that they knew nothing of the allegations investigated in relation to this child in 1981 or Child P in 1982. The latter was indeed never formally communicated to the Board.

3.78 One member 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. 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.

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

3.79 We were told that children made sarcastic comments about McLennan, calling him "Pervy Brian." We reiterate the comments made above with regard to similar behaviour set out as Clerwood Behaviour 1.

Y. The Report that Led to the High Court Trial

3.80 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.

3.81 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. In the course of the conversation, G told the member of staff about his abuse at Glenallan.

3.82 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.

3.83 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.

3.84 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.

3.85 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

Note: Some of these “themes” are based on information set out in the “Life in Care” section of the main report.

Isolation

3.86 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.

3.87 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.

3.88 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.

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

Appearance of happiness

3.90 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

3.91 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.

3.92 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.

3.93 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

3.94 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

3.95 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

3.96 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

3.97 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.

3.98 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.

3.99 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.

3.100 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.

3.101 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.

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

Later reports

3.103 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.

3.104 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.

3.105 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.

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

3.107 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

3.108 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.

3.109 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.

3.110 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.

3.111 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.”

4. INTERVENING EVENTS

4.1 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 referred to abusive behaviour in Cruachan and Redhall children’s homes in the 1980s and claimed that reports about abuse had not been responded to. A “cover-up” was alleged. Two names were given. One related to a former manager who had left the department’s employment and whose whereabouts were unknown. The other referred to a current senior manager. It was said that his continued employment by the Department inhibited the authors of the letter and others with concerns from coming forward.

4.2 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.

4.3 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. For reasons outlined in our main report, we considered that it would not be appropriate for us to undertake a detailed investigation of specific allegations.

4.4 The concerns addressed by us fell into three categories:

1. the allegations about the named senior manager who was still employed by the Council;
2. the concerns about the efficacy of current safeguards for looked after children; and
3. (to a limited extent) allegations about specific units.

4.5 Our conclusions were that:

1. No further concerns had been expressed about the senior manager on leave of absence and no evidence emerged to indicate that he had been involved in a cover-up. On the contrary, many staff wrote to us to the effect that he was approachable and 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.
2. Those concerns expressed in the letter about current practices and procedures with regard to reporting abuse are considered later in our report in the context of the Inquiry’s audit of current safeguards, with particular reference to the policy on “whistle blowing.”
3. With regard to allegations about specific units, we concluded that there were legitimate concerns about past practice. We found no evidence of a deliberate cover-up. Brief details about the concerns and our conclusions are set out below.

Cruachan

4.6 A social work investigation into practice at Cruachan in 1989 had resulted in a number of recommendations about unacceptable practices with regard to residents. These included, for example, keeping children locked up in their pyjamas as a sanction and forcible removal of their clothes for that purpose. Despite the issuing of guidance on Care and Control and the publication of the report of the Pindown inquiry in 1991, similar allegations emerged in 1992 and a further investigation was commenced by a social work department officer. This appears to have been suspended pending a police investigation which resulted in a decision by the Procurator Fiscal to take no further action. The Principal Officer for Children and Young People advised that the department's own investigation should be resumed after the conclusion of the police investigation. However, the then Director of Social Work decided to take no further action on the basis that the Fiscal was not proceeding further, and also on his understanding that the issues raised by the 1992 inquiry were appropriately addressed by departmental guidelines on practice matters.

4.7 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 (not the one who took leave of absence). 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 manager who conducted the investigations was reported to us as having been disorganised. That said, all of the information which we have received would demonstrate very clearly that neither he nor his line manager, who in fact was the senior manager who took leave of absence, were ever a part of any cover-up. Nor were they rewarded for not taking action.

Redhall

4.8 Redhall had been named in the anonymous letter, but no details were included. Although investigated by the police in 1992 at the same time as Cruachan, it has not been subject to the same amount of past scrutiny. It closed in 1984.

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

4.10 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.

Chester Street

4.11 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 the allegations and to speak highly of their care whilst there.

4.12 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.

Other Allegations

4.13 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.

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

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

4.15 The Departmental report of the 1989 internal investigation into Cruachan 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.

4.16 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 agree that would have been a preferable course of action at that time. 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.

4.17 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.

4.18 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.

4.19 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.

What lessons can be learned for the future?

4.20 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.

5. REMIT 2 – THE PRESENT

A. How information was gathered

5.1 The main report sets out how the information was gathered. In summary, we conducted an audit of current safeguards based upon a written statement by the Director of Social Work setting out his view of what safeguards were currently in place. We circulated information widely about the Inquiry. We interviewed selected members of staff and those who expressed a wish to speak with us. We visited all residential child care units within Edinburgh, as well as some outside the city which care for children from Edinburgh. We also read and analysed a great many policy papers and procedures.

5.2 Conscious of the public interest in the matters which we were addressing, we held a week of hearings in public 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.

B. Audit of current procedures, practices and guidelines

5.3 The Inquiry Team extracted a checklist of items from the Director's submission.

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

5.4 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.

C. Principles and Policies

a. Introduction

5.5 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. Principles and Policies - Main Themes

5.6 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.

D. Residential Care - General

a. Introduction

5.7 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. Residential Care - General - Main Themes

5.8 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 made from a corporate approach, there is no easy answer to the need for more resources for looked after children.

5.9 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.

5.10 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.

E. Dealing with Difficulties

a. Introduction

5.11 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. Dealing with Difficulties - Main Themes

5.12 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.

5.13 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.

5.14 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.

5.15 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.

5.16 The Department's concern to cover itself was also identified by many staff as the motivation behind the CALM (Crisis Aggression Limitation Management) training, the processes for recording and transmitting concerns and the requirements to carry out SCRO (Scottish Criminal Records Office) checks on the friends of looked after young people before they can stay overnight with them.

5.17 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.

5.18 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.

F. Keeping Watch

a. Introduction

5.19 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.

5.20 The inspection process has a vital role in ensuring that systems and standards are such as to minimise the possibility of abuse. Visit 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. Keeping Watch - Main Themes

5.21 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 acceptance that they must meet at least the standards required of independent units, and a strengthening of the independence of ELRIS (Edinburgh and Lothians Registration and Inspection Service) to allow it to perform a more clearly independent monitoring and enforcement role.

G. Identifying and Expressing Concerns

a. Introduction

5.22 Whilst the processes discussed above designed to "keep watch" are a necessary part of any system, it is also necessary to recall lessons from the past 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.

5.23 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. Identifying and Expressing Concerns - Main Themes

5.24 Whilst some of the people involved in the processes currently identified as safeguards may be "tuned in" enough to pick up on concerns themselves, they 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.

5.25 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 later in the report.

5.26 We reiterate at this point a conclusion reached earlier in the main report 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.

5.27 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.

H. Foster Care

a. Introduction

5.28 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.

5.29 The social work submission described the department's "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."

5.30 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."

b. Foster Care - Main Themes

5.31 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.

5.32 Foster carers need to know about complaints procedures and the roles of the Children's Rights Officer and Who Cares? so that they can advocate on children's behalf and also encourage children themselves to communicate concerns.

I. Children with special needs

a. Methodology

5.33 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 earlier in the main report in the context of corporate responsibility.

b. Special needs - Main Themes

5.34 While we feel 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.

J. Inappropriate Placements

a. Introduction

5.35 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.

5.36 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. Inappropriate Placements - Main Themes

5.37 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.

5.38 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 recommendations 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 (which restricts the departments ability to fill vacancies) 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.

K. Independent Persons

a. Introduction

5.39 The possibility of introducing "independent persons" as an added support for looked after children is referred to at various points in the report.

5.40 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.

5.41 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.

5.42 There is a need to distinguish 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 reasons outlined in the main report, that introduction of a new independent person to perform the latter function is unrealistic and often unnecessary.

b. Conclusions

5.43 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.

5.44 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.

5.45 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.

L. Independent organisations

5.46 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. Professional staff who act as a link between the Council and voluntary organisations also need clarity of role and expectation.

5.47 There is also a need for voluntary organisations to be clear within their organisational structures about allocation of responsibilities with regard to care and protection of children.

M. Staff

5.48 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. Good carers are crucial to good care. The issue of positive feedback is relevant to the introduction of an appraisal system discussed earlier in the main report.

5.49 The report discusses a number of issues about staffing about which concern had been expressed to us. These are important in themselves, but might also have an impact on morale:

- 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.

N. Historical Abuse

a. Introduction

5.50 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. 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. 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. Responding to Historical Allegations

5.51 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.

5.52 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.

5.53 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.

O. Conclusions on Remit 2

5.54 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.

5.55 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.

6. REMIT 3 – THE FUTURE

A. Text of Remit

6.1 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

c. Action plans

6.2 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. The number in brackets after each item refers to the number of the recommendation. The full text of the recommendations is set out in numerical order at the end of this report.

d. 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].

e. 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].

f. 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].

g. 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].
- h. 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].
- i. 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].
- j. Children’s Panel Training Organiser**
- Encourage panel members to consider creating opportunities to speak to children outwith the presence of their carers [85].
- k. Chair of the Children’s Panel**
- Continue attempts to obtain a degree of continuity of membership of children’s hearings [86].
- l. 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].
- m. 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

6.3 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.

6.4 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.

6.5 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.

6.6 The Purchasing, Planning and Commissioning Manager, (Children & Families) suggested further recommendations:

12. **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.
13. **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.
14. **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.
15. **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.
16. **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.

6.7 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.

6.8 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.

6.9 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 [in the main report], 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.

6.10 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.

6.11 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.

6.12 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.

6.13 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.

6.14 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.

6.15 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.

6.16 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.

6.17 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.

6.18 Allegations of historic abuse require a serious, thoughtful and concerned response. As indicated in Chapter 19 [of the main report], 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

6.19 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

6.20 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 were suffered by them.

G. Minimising Child Abuse - How assured can we be?

6.21 Our remit requires us "to assure Social Work Committee and the public that every measure is in place to minimise child abuse."

6.22 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.

6.23 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.

6.24 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.

6.25 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.

6.26 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.

7. 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.