CLYDE&CO

STATEMENT

OF

AMANDA HATTON

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City of Edinburgh Council

PERSONAL & PROFESSIONAL BACKGROUND

1. My name is Amanda Hatton. My date of birth is [redacted] 1970. I am Executive Director for Children, Education and Justice Services at the City of Edinburgh Council ("CEC"). I have held this role since November 2021. I am a Social Worker by profession. I hold a master's degree and Diploma in Social Work. A copy of my CV has been provided to the Inquiry.

2. Prior to moving to Scotland, I was Director of Children's Services in Lancashire between February 2017 and July 2019. I was then Corporate Director of Children, Education and Community Service (and from October 2020 Director of Adult Services) at the City of York between August 2019 and October 2021.

3. At CEC I am the Executive Director for Children, Education and Justice Services (and the Chief Education Officer). I am responsible for Children's Services. That includes children's social care and early help. I have overall responsibility for children's residential care, foster care and the council's statutory Social Work Services. I am the line manager for the Chief Social Work Officer. I manage the Chief Education Officer who has responsibility for school and early years, adult education and lifelong learning. I also have responsibility for our justice services – this includes children in conflict with the law and adults who are in custody and the justice system. My remit includes responsibility for all parts of children's social care. I report to the Chief Executive of CEC. Until June 2024 that was Andrew Kerr. It is now Paul Lawrence.

4. I have three Service Directors reporting to me as follows:-

- Kathy Henwood, Service Director Children's & Justice Services
- Rose Howley, Service Director Performance, Quality & Improvement and Chief Social Work Officer
- Jackie Reid, Service Director Education and Chief Education Officer

ACKNOWLEDGMENT

5. Whilst CEC have issued a formal response to SCAI's framework document setting out its position, I personally wish to acknowledge on behalf of CEC that there was widespread abuse of children in our care at the establishments being examined in this case study. Children suffered sexual, physical and emotional abuse there. The evidence suggests that abuse was still happening in our houses as recently as 2019. That is appalling.

6. I also wish to acknowledge that there were widespread failures in historic systems for safeguarding children as well as significant failures by CEC in its response to abuse and in the process of implementing changes as a result of investigations into abuse.

7. I am very sorry to say that CEC's record in this area is far from good. It is clear that there were a number of missed opportunities for CEC to improve systems and practices. There is a concerning pattern of a failure to learn lessons from inquiries and investigations. It is quite clear that CEC could have prevented a lot of this from happening and that there were failures both at local and organisational management levels. There is also an extremely concerning history of people within CEC either being discouraged from raising concerns or not feeling safe when they did raise concerns.

8. Given that history, the question can quite justifiably be asked of whether there can be any confidence that history will not repeat itself again. This statement is not intended to reflect a comprehensive response to all of the evidence led in this case study. However, I have attempted to convey some of my own experiences since starting with CEC in 2021. I have also aimed to address some of the areas where concerns have been raised and to hopefully give the Inquiry and those for whom we are corporate parents some reassurance that things are changing for the better.

OVERVIEW

9. When I arrived at CEC in November 2021 we were coming to the end of the Covid pandemic and we were still subject to Covid restrictions. Everyone in central offices was working from home and there were restrictions on office uses and home visiting.

10. As a general overview, I considered that the general performance culture in Children's Services was not where I would have expected it to be. As one key example, there was a reluctance to carry out audits.

11. This was partially due to Covid. Some difficult decisions had been made when Covid started. One of those decisions was to stop doing case audits. There had therefore been no audit activity during the pandemic. The basic building blocks of timely assessments and outcome-based planning for children were not in place. There were significant waiting lists for child protection support. 75% of our placements into residential care were emergency placements.

12. I also realised quite quickly that the quality assurance processes which I would have expected to be in place were not as robust as I would have expected. I would have expected to see case audits, children's reviews and the voice of the child being recorded in the records with key performance dates.

13. There were also a lot of people who had worked at Edinburgh for a long time. I considered this had resulted in complacency in relation to the quality of practice. It was not what I was used to coming from other large local authorities. I felt that we needed to take drastic action to improve the quality of practice to ensure that we were properly fulfilling our role as corporate parents.

14. We have done a lot of work to make improvements in Children's Services since I joined CEC. We are on an improvement journey. I am not saying that everything has changed nor that everything is perfect. It certainly is not perfect. There have been some areas where it has been difficult to bring about change. However, I consider that we have made a number of meaningful improvements during my time here. It is my firm view that CEC is moving in the right direction. The overall improvements in our Care Inspectorate inspection report scores for our children's houses would support that view. All of our residential houses are graded as 4-Good. It is also supported from the feedback we have received from the champions board and from staff in our residential houses. We have agreed that we will move to a maximum of 6 young people per house. We have also introduced a robust matching process, which sees young people better matched to houses. Each of our houses have recently individually been awarded The Promise award. We have introduced an edge of care service to work intensively with families and reduce the need for children coming into care and therefore reduced the need for emergency and unplanned placements.

15. We also have a number of great examples of where children will be leading practice and opportunities for care experienced people to share their experiences. We have funding for a peer mentoring programme between people with lived experience of the care system. We are setting up home packs for care experienced people setting up homes on their own. We have funding for an exchange trip to another country for young people to look into a different care system; an app for information sharing and communication for the care experienced community; and a project for catch up learning to help care experienced adults improve their numeracy and literacy.

EDINBURGH SECURE SERVICES ("ESS")

16. The first reference we have found in historic records to the name Edinburgh Secure Services is in the early 2000s. It was a service within the Children's Services division of the social work department at CEC. ESS was registered as a service with the Care Inspectorate. It no longer exists as a service. Prior to that time the establishments within ESS were just referred to by their own names.

17. The establishments with which Edinburgh Secure Services was involved which form part of this case study were St Katharine's and Howdenhall/Liberton. Wellington School does not appear to have been part of Edinburgh Secure Services.

18. Wellington School closed in 2014. St Katharine's Secure Unit closed in December 2016. It re-opened as a residential centre for unaccompanied asylum-seeking children in 2017. It fully closed in January 2018.

19. Howdenhall closed as a secure unit in June 2023. I address the reasons for that more fully below.

20. ESS no longer exists. CEC no longer has any secure care provision. However, both the Calton and Chalmers units remain operational but as stand-alone children's houses.

HOWDENHALL

21. Not long after I arrived I was made aware of some problems with Howdenhall. The Interim findings from the Mackinnon report had been issued on 21 June 2021 prior to my arrival. There was an improvement plan in place. This was intended to ensure that the problems encountered at Howdenhall were not replicated in the present day or across the rest of the residential estate.

22. Some changes had already been made prior to my arrival. In particular a number of staff, including Scott Dunbar who was the senior manager for looked after children, had been suspended. He had been replaced by Steve Harte who was acting Head of Service.

23. The structure was that there was a Headteacher at the school within Howdenhall and also a Head of Care for the establishment. That included both the secure and non-secure close support unit. The Head of Care reported to the Acting Head of Service – Steve Harte. Steve Harte reported to Jackie Irvine (Service Director and Chief Social Work Officer.

24. A new interim head of service, Mark Crawford, was appointed from outside the service. In addition, two additional managers above the original staff compliment were appointed. Prior to its closure, Mark Crawford was appointed as Head of Howdenhall. He is a very experienced Social Worker. He had a real drive for a child-centred approach. He and Steve Harte were tasked with driving the cultural changes needed to go with the action plan (discussed below). Steve Harte is now Head of Service for Corporate Parenting in Children, Education and Justice Services.

25. In January 2022 Pauline McKinnon's whistleblowing report was issued. The report was highly critical of ESS and the Council. It was clear from the findings that were significant problems at ESS and that there had been numerous missed opportunities to put them right. Further evidence that has come to light through the Inquiry indicates that there were previous occasions upon which concerns were raised. There is a concerning pattern of abuse, investigation and inquiry followed by a period of attempted or limited change with no lasting impact.

IMPROVEMENT PLAN

26. Following publication of the report, a consolidated action plan pulling together the recommendations from the McKinnon report and the Gordon Collins significant case review in 2017 was produced. One of the main criticisms of the McKinnon report was that there had been a failure to follow through the actions from the Gordon Collins significant case review. It was therefore imperative that a consolidated plan was put together, progressed and monitored.

27. I acted as a critical friend in development of the action plan. I was really keen to ensure that the action plan was straightforward and that it had clear targets with the names of those responsible against the targets.

28. I also wanted to have a robust evidence base that the recommendations and actions were implemented and were still happening. I did not want a repeat of what happened after the Gordon Collins serious case review. In that instance there had been a detailed action plan but no real critical analysis or scrutiny about whether or not what was being said to have improved had actually improved. Senior managers were taking what they were told by ESS managers at face value.

29. Instead of a clear bullet pointed plan, what I received was an incredibly detailed and overcomplicated plan with no real ownership. This was produced CEC's quality assurance department. The initial plan was too complex and it was not appropriately sequenced. It needed to be simplified and the intended outcomes needed to be clearer. The plan was revised and finalised for presentation to the elected members of CEC.

30. The McKinnon report was presented to the Governance, Risk and Best Value Committee of CEC on 8 March 2022. Given the significance of the findings, the Monitoring Officer reported it to the full Council on 22 March 2022 under section 5 of the Local Government & Housing Act 1989. We provided a response to the report and a copy of the Consoldiated Action Plan. It was recommended that the work was supported and for the report and Consolidated Action plan to be referred to the Education and Children and Famlies Committee. It was acknowledged at this time that a significant challenge to implementing the full action plan was the "*culture*" among some staff and managers. The conclusions of the McKinnon report were accepted by CEC.

31. Oversight of the Consolidated Action Plan was to be undertaken by a new Governance Oversight Group, which was established in January 2022. This new group was to take a governance and scrutiny role which included (1) quarterly visits to Howdenhall; (2) quarterly reports of progress against the improvement plan and the independent monthly reviews; (3) quarterly report from corporate parenting officer regarding voice of children in secure care; and (4) the establishment of a performance and improvement team.

32. I led on significant due diligence activity in relation to CEC's Children's Services more broadly. That resulted in a self-assessment and improvement plan for Children's Services which was presented on 27 April 2023. The actions from the ESS Improvement Plan were amalgamated into the wider improvement plan for the whole of Children's services. This was because I considered that we needed a whole system improvement, and not just an improvement in one service. Care planning for children is a field work activity. However, it is crucial to the care of children in secure and residential care. Allied to that, review officers are key in ensuring care plans are in place and are meeting the child's needs. Having a number of separate improvement plans risked us not getting the system right and actions falling through the gaps. I therefore wanted one plan and one reporting system in place.

33. There have been regular updates to committees on progress against both the ESS and wider improvement plans which can be provided to the Inquiry. Those reports demonstrate the particular pieces of work which have been at particular points in this journey from January 2022 to the current time.

34. There have been updates to the Education, Children & Families Committee on 3 May 2022, 15 November 2022, 31 January 2023, 27 April 2023, 5 September 2023, 7 November 2023, 23 January 2024, 16 April 2024, 6 June 2024, 3 September 2024 and 21 November 2024.

35. There have been updates to the Governance, Risk and Best Value Committee on 8 March 2022, 14 June 2022, 7 November 2023, 20 February 2024, 7 May 2024, 4 June 2024 and 31 October 2024.

36. There have been updates to the elected members at full Council meetings on 22 March 2022, 30 June 2022, 28 September 2023, 27 June 2024 and 26 September 2024.

37. There have also been B Agenda item updates (which are not in the public domain) on 8 March 2022, 22 May 2022 and 27 April 2023.

38. The most recent report to Education, Children & Families Committee was on 21 November 2024. In some areas progress had not been at the pace expected. However, overall progress had been made in all areas of the Children's Services Improvement Plan. This has also been validated by the quality assurance team as critical friends.

39. I have now commissioned a full review of the plan and a refresh which starts with an away day on 28 January 2025. The purpose of these is to ensure that the areas of delivery are consolidated and that there is consistent ongoing delivery in those areas. I also want us to aim to be aspirational in our development and improvement actions, for example having a more detailed focus on educational quality and outcomes for our care experienced young people. The revised plan will be presented to Committee for scrutiny in June 2025.

40. I have outlined below some of the key changes which we have made to children's services.

STRUCTURAL / GOVERNANCE CHANGES

41. The current structure (discussed in paragraphs 3 & 4) has been in place since August 2023. When I arrived in November 2021 the Service Director and Chief Social Work Officer posts were the same person – Jackie Irvine. We did not have a Service Director for Education. I therefore briefly held the Chief Education Officer role myself.

42. Jackie Irvine left the Council in September 2022. I covered the Service Director role at that point. Rose Howley acted up into the Chief Social Work Officer role. Kathy Henwood started with the Council around July 2023 as Service Director for Children & Justice Services. Rose Howley became the permanent Chief Social Work Officer around September 2023.

43. On assuming my role, I considered that certain changes were required to the structure of the organisation. This was due to the amount of work involved in the different roles, the size of Edinburgh as a local authority and ultimately to improve the adult and children's services that we were offering. In my opinion to expect one person to be Chief Social Work Officer and Service Director was too much. Separating out those two roles also allowed for more scrutiny to be brought to the decision-making process. Essentially it introduces another set of eyes for quality assurance purposes. Under the previous structure, the head of quality assurance was marking their own homework.

44. There have been a lot of changes in senior leadership roles for children's social work at CEC over recent years. The current senior team of me, Rose and Kathy has been in place since July 2023.

45. I considered some further structural changes were needed to ensure that CEC had a robust quality assurance system in place. We appointed an independent chair to our Child Protection Committee. That is Lilian Pringles.

46. We established a specific corporate parenting team headed by Emily Dempsey. The team includes a care experienced worker. We also established a corporate parenting hub. This is a building for care experienced young people to meet and get support from the corporate parenting team.

47. I moved the responsibility for the Reviewing Officers into the quality assurance part of the Social Work Department. That meant that they were no longer aligned to the services that they were working with but were more independent.

48. Reviewing Officers are social workers who play a key role in ongoing learning and improvement of services. Part of their role is to review care plans for children who are in our care to ensure they are meeting their needs. They are also expected to call out poor practice and to help implement change. Previously, the Reviewing Officers had been sidelined and there was no escalation process in place. Essentially when they raised issues they were ignored and there was previously no formal process in place for them to escalate this. An escalation process has now been put in place. That process is overseen by the CSWO.

49. There are currently 12 Reviewing Officers in the team and a Team Manager. The role of the Reviewing Officer in Edinburgh has changed significantly over the last five years and has been strengthened by both the commitment of the team and the work of The Promise. The Team Manager chairs the National Reviewing Officer's network and has recently been involved in developing the "National Reviewing Officer's Handbook" which is a good practice Guide for RO's across Scotland allowing them to offer consistency of practice and encouraging them to "Keep the Promise " This has been endorsed by Social Work Scotland and the Chief Social Work Officer Group and will be introduced to the Scottish Government for further discussion.

50. In addition, I established an Improvement Board around August 2022. I was the chair of that Board. The Board included all relevant officers from Children's Social Care. I invited the Care Inspectorate to attend those meetings as a critical friend. We also invited Who Cares? Scotland and the Office of the Children's Commissioner.

51. The Improvement Board meetings have now been moved into monthly performance meetings.

ADMISSIONS TO SECURE CARE

52. On receipt of the McKinnon report findings, I took the decision to restrict admissions to secure care until the improvement works were done. A freeze was put on accepting any further young people into the unit. That was until it was agreed by me and the Chief Social Work Officer (Rose Howley) that the improvement was sufficiently embedded to ensure appropriate care and support. Subsequently a capped occupancy at 50% (3 young people at any given time) was put in place. This was increased to 4 on a short-term basis to ensure young people requiring secure care on an emergency basis in Edinburgh could be accommodated. All admissions to secure care required the agreement of me and the CSWO.

53. Following the closure of the service in June 2023 (discussed below) we no longer have any young people in secure care within Edinburgh.

FILE REVIEW

54. I commissioned a further review of files for children and young people who had been cared for at ESS. Previously we had identified 30 children who had complained as those were complaints which were recorded in the complaints log. What became clear however was that there were a significant number of other complaints which had not been recorded in the complaints log. Part of the reason I asked for this work to be done was because I thought it was likely that the problem was much larger than the 30 children who had been identified. The number of children affected was potentially much larger.

55. A dip sample of records was undertaken by Josephine Lee. This was produced in February 2023. This was to try and gauge the extent of poor practice in Edinburgh Secure Services and Close Support Units between 2008 and 2019. Of the 34 files reviewed, 17 contained information that was considered concerning and could amount to maltreatment. Of those 17 files, 11 files contained information that evidenced maltreatment. 4 of those young people had been identified in the initial cohort of 30 files that had been reviewed.

56. I then commissioned a further piece of work to be undertaken in reviewing all of the historic files for Howdenhall. In order to undertake this piece of work I recruited an experienced social worker. She was tasked with look in more detail at individual files for children.

57. This individual has been engaged as an independent social worker. She is not a CEC employee. I cannot say specifically say where she worked previously as I understand that she is subject to non-disclosure requirements. However, she has considerable experience in the subject of network abuse.

58. This work is ongoing. However, significant concerns beyond those which had already been identified by the McKinnon report came to light as a result of this review. A police investigation has now been opened into those concerns. That includes concerns in relation to children who were in care at other CEC houses and children who were in the community.

59. I have recently identified an analyst to assist with mapping this work. This is a difficult piece of work and finding analysts with the requisite expertise is very difficult. However, we have now identified one and we are going to commission them. We are also recruiting an additional senior officer to link all of the investigation together.

CHILDREN IN SECURE CARE

60. One of the reasons I decided to close the secure service was that Edinburgh's secure numbers were higher than I expected them to be. Coming from south of the border, I would have expected the numbers to be much lower. Edinburgh also had repeated use of secure care for the same child. At the point that I started, Edinburgh had 12 children in secure care for welfare purposes. (some at Howdenhall and some in other placements). Today we have no children in secure for welfare purposes – the only children we have in secure are there as an alternative to adult custody and placed via the Sheriff.

61. I therefore considered that we had to look at why we were using secure care. I discovered that Edinburgh was the only Scottish local authority with its own secure

provision. It should be a really rare thing to recommend secure care for a child and to put the child into a secure setting.

62. I considered that in general terms CEC were not care planning properly. We had children with complex needs. The planning and support around those children was not how I considered it should be so, in some cases, their complex needs were becoming chronic. Children were also being put in secure care for their own protection to stop them being exploited which is outmoded practice – the focus should be on working to identify and target perpetrators not re-victimising young people. There was an element that because CEC had secure provision, it became tempting to place children in the secure provision because there was an available space and there was considerable pressure from partners to do so.

63. We closed the secure provision in June 2023. Whilst the findings from the Mackinnon review were undoubtedly relevant to that decision, the main reasons I chose to close it was I did not consider that CEC had a need for its own secure provision and that the staff team could be better used to work intensively with families to prevent reception into care.

64. The initial intention had been for the building to be repurposed as a residential home to support children when they first come into care. It was to offer intensive support with an aim to returning children to their home within 12 weeks. However, it became apparent that we could not make the building fit for that purpose.

65. It became clear that the building, even with doing work to it, was not a place that you would want children to live. There were also complications around who owned the building.

66. Howdenhall now has an edge of care team working in it. That team provide intensive family support designed to prevent family breakdown. The team work with the family in their home. They use the building for work purposes. We did have some discussions with the Care Inspectorate about the potential of registering a respite centre at Howdenhall. Some young people needed somewhere to go from Friday to Monday to calm things down and then go home. However, in the end we elected not to proceed with that. There is also now a certain stigma attached to the building that it would be difficult to rehabilitate.

67. We currently have seven Edinburgh children in secure care. They are in private secure units. All of these children are being accommodated for criminal justice reasons. None of them are being accommodated for welfare reasons. There has been an increase in numbers as some of these children would previously have been accommodated in the custody estate by the Scottish Prison Service. We have no children in secure on welfare grounds.

68. My view is that, if we get to the point where we have to put a child in secure care, the system has failed. It should only be happening in exceptionally rare circumstances.

69. I can see an argument that secure care still has a place in some exceptional cases. Historically sometimes secure care was used when a child's mental health was not ok. However, that child needed mental health support and not secure care. My hope is that, as practice improves, there will be less and less need for any secure services.

70. In the 1970s lots of children were in secure care. However, our understanding of trauma has now significantly changed. Our understanding of what children need to thrive has also changed. There has therefore been a significant cultural shift since

that time. In the 1970s we used to send children to borstal because they were considered "*naughty*". There has been a shift away from assessing the child on the basis of their behaviour to a more trauma informed approach.

71. For some children residential care is the right place. That can especially be the case if an adoption breaks down. Some children need a very loving residential context to trust again before they can go to another family. However, they do not need to be locked up to do that.

72. Ultimately, we have to do what is right for every child. We can see from some of the evidence led in this case study that historically Howdenhall was being used as an assessment centre for children with all sorts of different needs. Whilst I am aware that assessment centres were not uncommon in the past, it is unusual for them to have been closed conditions. Little consideration appears to have been given to whether closed conditions would be appropriate for the children placed there at the time or to the mix of children there.

RESTRAINT/ DE-ESCALATION

73. One of the themes that we have seen through this case study, and through the significant reports which have been carried out by CEC and their predecessor authorities is the use of restraint. It is clear that at Howdenhall restraint and single separation were being used unnecessarily and inappropriately.

74. The model which should have been in use at ESS was the CALMs model. Theoretically it was meant to be being used by staff prior to my arrival. However, it is clear on the basis of Pauline McKinnon's report that it was not being implemented – at least at Howdenhall. Some staff did not appear to understand fully that it involved de-escalation.

75. We rolled out a training programme to ensure that everybody received CALMs training and that their training was up to date. It took longer for us to do in person training than I would have liked due to Covid. However, we did have some online training.

76. CEC have undertaken a joined-up piece of work with Kibble and Aberlour as a pilot scheme. This is exploring the aspiration of becoming a "*no restraint*" organisation. We found that through the pilot our use of restraint dropped significantly. There was a point where we had not had any restraints in our residential estate for six months.

77. The work which was done with Kibble and Aberlour came about as a result of the Promise. Those organisations had done a lot of work on looking at the possibility of having a no restraint culture. It provided us with the opportunity to learn from them. We were able to ask how they managed the complex behaviours that they saw in secure care. It provided us with an opportunity to learn from their culture and their methods.

78. An example of that learning is knowing what is going on for a particular child. That involves doing work with that particular child to understand their triggers. You should have a clear de-escalation plan for the child. That involves quality staff handovers so that staff do not come on shift in a situation where things can escalate. If they are in an escalating situation, how do they manage that and de-escalate it? Staff also have to understand the mix of young people in the house and how they could potentially trigger eachother.

79. Historically, I think that the training was maybe not great. There are also aspects of poor recruitment practices which may have played into this and a lack of a training plan. There appears to have been a lack of good supervision and management support. There were also issues with agency staff being relied upon heavily and gaps in rotas being filled at the last minute with no consistent teams working together. There was also a lack of care planning. If you do not know the children, then it is going to be difficult to manage the children. There was a lack of policies and procedures and the lack of clarity over who was supposed to be doing what. All of those factors together contributed to what happened at ESS. The impression is of a culture which focused on control to the detriment of care. That is not the way it should be. The principal focus should be on care of the children. I hope that the changes that we are implementing are driving an environment in our residential houses which is focused on love and care. This is certainly an area of strength in our most recent inspection reports where children and young people talk of feeling loved, safe and happy.

80. The issue of "toy-fighting" has been raised in evidence before the Inquiry and in some of the investigation reports. It appears that in the 1990s and early 2000s, this was an accepted practice at ESS. It certainly is not an acceptable practice now. I am aware that by 2010 clear guidance was being provided to staff that it was not allowed under any circumstances. It is clearly a practice that is open to abuse of power dynamics by male staff. It could also cause a blurring of lines of acceptable behaviour for young people.

RECRUITMENT/STAFFING

81. Separately to the ESS improvement plan, CEC undertook a review of recruitment practices within social work. The work from that review was brought together with the other plans to form the consolidated improvement plan.

82. We now have a focus on recruiting staff for the individual houses rather than generic recruitment. Each individual house has its own manager. The houses have different characters and there are different groups of children. We need competent residential officers but we also need them to gel as a team. I considered that the management in the houses needed to be more involved in recruitment as that meant they would be able to identify those candidates who were the best fit for their teams, houses and children.

83. In general terms I consider that our HR practices are better now. We have a new HR system. It is more stringent on references and the basics around disclosure checks . We also have a refreshed workforce strategy as an organisation and are working on specific plans for children's services, for example supporting staff who don't have a social work qualification to gain this through a work based route.

84. As part of our overall improvement plan, we undertook a significant recruitment drive. We recruited 24 new social workers and 3 new heads of service. We increased the number of managers. A manager was placed in each of CEC's residential houses. Previously managers would be managing more than one house.

POLICIES,PROCEDURES & RECORD KEEPING

85. It is one thing having policies and procedures and making sure they are up to date and compliant with legislation. However, the other significant aspect of this is making

sure that people understand them and follow them. Historically at ESS it appears that we did not have either. There was a unit handbook. However, it was not always consistent with other CEC policies and procedures and was outdated.

86. The recording practices at ESS were not great. Particularly recording was poor around critical incidents or restraints. The necessary debrief with the young person and staff afterwards was not always being done or recorded.

87. Following on the review, a revised process and form were devised for the use and recording of restraints in residential units and the handling of complaints against residential care staff. Whilst this resulted in a change in practice, the underlying procedure itself has not been updated from the 2019 version. The CSWO has requested that the procedure itself is updated as a matter of urgency.

88. A new standalone single separation procedure was developed. That involved a clear procedure for recording episodes of single separation including (i) a clear context leading to single separation; (ii) a clear record of all staff involved; (iii) clear record demonstrating consideration of time required for a young person to be held in single separation; and (iv) regular audit. This was only for secure and is now no longer in operation.

89. In addition to this practice standards have been developed with social workers in relation to all aspects of a child's journey, including visiting children. So there is clarity of expectation and we are able to build performance systems to monitor practice compliance.

90. Another relevant issue relates to the CEC recording system. CEC's present recording system (SWIFT) is outdated and not child-centred. We have now commissioned a new system (Mosaic). That system is used in most other local authorities. The advantage of the system is that all of the child's information is stored in one place. It also means that we are able to obtain much more up to date performance information. This system also has a complaints module so all of the complaints information is in one place.

91. Mosaic also allows you to audit who has accessed a child's record and when. You will also be able to tell if something is missing or has been deleted much more easily, which will be a significant improvement on the current system.

92. On the subject of record keeping, I am aware from press coverage presented by the Inquiry that a number of children's files were left at Wellington after the establishment closed down in 2014. I do not know how that happened. However, it clearly should not have and was a failure in the management of sensitive and confidential information.

ALLEGATIONS, COMPLAINTS & INVESTIGATIONS

93. We know how difficult it can be for children or young people to make a disclosure of abuse. In the Gordon Collins Serious Case Review it is clear that the conditions were not in place to make it easy for children to make a disclosure. One recent change for CEC is that, , along with Police Scotland and neighbouring authorities we now have two houses which are part of the Bairns' Hoose project. The Bairns' Hoose provides children and young people with access to trauma-informed recovery, support and justice. It includes specialist provision for children who make disclosures and has specific provision for trauma-informed interviews. I have visited the houses

and they provide a very welcoming and safe environment for children and young people to get support at such a difficult time.

94. We have rolled out training to all relevant staff on the procedures that they must use in relation to complaints made against staff involved in implementing a restraint or physical intervention. All residential workers were made aware of (i) the allegations of abuse against staff procedure; and (ii) the whistleblowing policy.

95. We have introduced a procedure for monitoring and tracking of complaints by Team Leaders, Team Managers and Service Managers. A regular meeting has been established between the Council's complaints service for Children's Services and a Team Leader from Residential Services to review themes from complaints and confirm that allegations of abuse against staff are not being wrongly recorded as complaints.

96. We have undertaken several audits of our complaints activity. The most recent audit report looking at historical complaints within the Children's and Education Services reported in August 2024. The report reached an overall assessment of "limited assurance". That means that there were significant gaps, weaknesses or non-compliance with procedures and that improvement is required to the system of governance, risk management and control. This particular audit looked specifically at historic complaints rather than current practice. However, we clearly still have further work to do on complaints handling. As part of the plan to address that we are commissioning a role equivalent to the Local Authority Designated Officer ("LADO") in England & Wales. That person will be a central point of contact for complaints involving children and young people. I have discussed this more fully below.

WHISTLEBLOWING

97. The Inquiry will be aware of the independent reports carried out by Suzanne Tanner, KC into Sean Bell and CEC's whistleblowing culture. The recommendations from those reports have given rise to various changes including in relation to whistleblowing. A detailed action plan around improvements to whistleblowing was produced. The most recent version of that was presented to the Governance, Risk & Best Value Committee on 17 September 2024. A copy of that has been provided to the Inquiry along with this statement.

98. The Edinburgh City Council whistleblowing procedure is now very open. People can blow the whistle anonymously.

99. The Council employ an independent third party called Safecall to oversee its whistleblowing complaints. The whistleblowing policy is publicly available on the internet. The policy is for City of Edinburgh Council employees, workers, elected members, contractors, agency workers, and those undergoing training or work experience.

100. Safecall man an external whistleblowing hotline 24 hours a day. The Monitoring Officer (who is Nick Smith, the Council Service Director, Legal and Assurance) has overall responsibility for whistleblowing. Under the policy, concerns can be raised in relation to criminal activity; a failure to comply with any legal obligations; miscarriages of justice; danger to health and safety; damage to the environment; and deliberate concealment of any of those matters. The whistleblowing policy makes it clear that this is not an exhaustive list and that anyone with serious concerns of wrongdoing or dangers are encouraged to come forward and to voice those concerns.

101. Any disclosures made under the whistleblowing policy are treated sensitively and subject to confidentiality. The policy has detailed provisions around confidentiality and anonymity protections.

102. The Council now also have speak up champions. These are frontline staff who provide support and guidance to anyone wishing to raise a concern.

103. There is a whistleblowing sub-group on the Governance Risk & Best Value (GRBV) Committee who monitor activity and undertake regular audits.

104. A dedicated investigations team has been fully operational since October 2022.

105. CEC are perhaps the only Scottish local authority which has an arms length whistleblowing provider.

106. One of the unintended consequences of having such an open whistleblowing policy is that it can be used against people who are trying to create change. Anonymous and vexatious complaints can be received and investigated. Although not common there is clearly scope for the system to be misused.

STANDARD OF EDUCATION

107. My view is that the standard of education in secure care was poor. As one example we had one child in secure care for nine months on their own. That must have been damaging. Where the staff in education were unable to cope with the child's behaviour, rather than using the techniques that staff in an additional needs school would have used, they would ring the care staff. Therefore, in Howdenhall if the teachers could not manage you the care staff would then come in and restrain you. It is difficult to see how a child could feel safe in that environment. There is also something about the closeness of living and being educated in the same place with no external life which is at best not nurturing and at worse abusive.

EXTERNAL VISITS

108. I considered that it was important that there was increased senior leadership visibility and oversight. I visited Howdenhall following on the committee meeting on 8 March 2022. I spoke to both young people and staff.

109. On the education side we carried out a full review. It was clear that the standard of education being provided was not satisfactory. On the care side our visit reinforced that it was the right decision not to allow new children to be placed at Howdenhall and to restrict the number of placements there. At the time of our Spring 2022 visit Howdenhall was at an early stage of its improvement journey.

110. The actual building itself had become outdated. It would have been difficult to care for six children there as it was not configured well. I confirmed personally it was not a place where I would want to put children. Mark Crawford was driving the improvements. There was a real focus on the physical environment. We were making the bedrooms more homely. The garden was being redone. There were two entrances. One was a front door but it was also a gate that felt like a prison gate

111. I visited on approximately a monthly basis. I subsequently took some education and Children and Family Committee members out to see Howdenhall.

112. The Chief education officer and I held open meetings for all staff across the residential and secure estate. We then set up a full change project for the future of Howdenhall. This was led by a change manager who undertook extensive consultation on the options for Howdenhall.

113. We now have elected members who are linked to the children's houses. It means they have an interest to ensure practice in that house is good. We try to make it a house in the particular councillor's ward. Our house at Drylaw did a McMillan Coffee Morning where we had the families of children and elected members came and I also went. I am trying to work to open the houses up more.

COMMENTS ON PAULINE MCKINNON'S STATEMENT

114. I have had the opportunity to consider the statement provided by Pauline McKinnon. At the outset can I say that I am very grateful to Pauline for all the very diligent work that she undertook in relation to ESS. I am very sorry for the way which she felt when carrying out her investigation. I undoubtedly think there will be some learning for CEC as to the additional support and reassurance they can provide to investigators in light of Pauline's experience.

115. I was not directly involved in the receipt of the whistleblowing complaint as it predates my time with CEC. This was passed by Jackie Irvine who at the time was the chief social worker to Nick Smith who is the Monitoring Officer. It was then progressed through the whistleblowing process to Safecall. The approach taken was considered by the Tanner KC review team who were satisfied that matters were being progressed appropriately through the relevant processes, which included investigations by both Police Scotland and Safecall. However, it is clear that Safecall's role in the investigation of the ESS whistleblowing complaint was not as significant as I would have expected to see. I do not know the precise reasons for this. However, I understand it was largely due to Covid restrictions as well as the need for social work expertise. The investigation clearly needed to be done by someone with an understanding of social work practice.

116. It is disappointing to hear Pauline's view is that she did not receive regular supervision while she was undertaking her work on the report. She should have been receiving regular supervision and support from her line managers. Safecall were also supposed to be supporting her on the investigation. However, importantly, her investigation was very thorough and resulted in a report to full Council. This has certainly helped uncover many of the concerns which have come to light. I know that the Monitoring Officer thanked her for her excellent work at the time.

117. What I can say now is that CEC have established an independent investigation team. Investigations are therefore no longer carried out in the same way. I would therefore hope that Pauline's experiences would not be repeated. Investigations are resourced from within the investigation team which is managed within the Legal and Assurance Division. Where concerns relate to children and vulnerable people they are referred up to Rose Howley as chief social work officer. For example, the team working on the file review (discussed above) receive supervision from Rose. We are also looking at external clinical supervision for this team.

118. I can identify with how Pauline felt during her investigation. As a female who has come in to CEC and has tried to change practice for the better I can say that it is extremely hard at times. It can still be very challenging to get information out of people. I personally have encountered a lot of resistance.

119. We have had a number of people who have left their posts or who have been supported to leave during my time at CEC. However, in some quarters there is still a reluctance to have practice opened to scrutiny and change. Getting audits done in some parts of the organisation can be an absolute battle. I am saying that as the Executive director. I can only imagine what it would have been like for someone in Pauline's position.

120. I can understand Pauline's comments around the ESS improvement plan. I agree with her that an industry grew up around it. It became far too complicated. However, I consider that the action plan and the steps taken to implement it have been effective. I asked Heather Smith, one of Pauline's former colleagues, to undertake a review of the action plan and to look at the evidence underneath that. Heather is comfortable now that the changes which were said to have been made have been made and that we are seeing noticeable change.

121. I broadly agree with Pauline's comments about the culture within the City of Edinburgh Council. The Tanner inquiry laid bare some of the cultural issues with children and families in particular. I also agree that quality assurance was not operating as it should have been. The senior manager in that service was supported to leave the organisation. We have been supporting Pauline's former line manager to become more professionally assertive in his role.

122. I can understand why, when I arrived, Pauline felt that things became more chaotic. In order to make changes to the organisation we had to support a number of people to leave. We had to challenge and change practice. There was therefore a great deal of change happening for longer term benefit. I can see however in the short term it may just have seemed like an increase in chaos.

123. I am very grateful to Pauline for all of her hard and diligent work. I wish to express my gratitude and the gratitude of CEC to her for that.

DISCIPLINARIES

124. CEC's HR and legal teams reviewed all recorded episodes and incidents highlighted within the findings of the Mckinnon report to decide whether any further action in relation to staff was required.

125. A number of workplace investigations were instigated. Several current and former members of staff were referred to the Scottish Social Services Council.

126. One member of staff raised a grievance against CEC in relation to the number of times he had been suspended and subject to disciplinary action when no allegations against him were substantiated.

127. Some limited disciplinary action was taken against members of staff. One member of staff was demoted. Another resigned at the point of disciplinary action. Another was issued with a final written warning. However, no member of staff was dismissed as a result.

128. A further, more in-depth review of some records has taken place, in part prompted by further information received through the inquiry. This has led to ten further workplace investigations being progressed. Those are still ongoing.

129. It is important to say that where any wrongdoing is established we will take appropriate action.

POLICE INVESTIGATION

130. There have been a number of police investigations over the years. On some occasions when there was a restraint at ESS, staff would contact the police.

131. Police Scotland reviewed all of the allegations of criminal behaviour arising from the Mckinnon report. However, I understand they found that there was no basis for further criminal investigation. I remain extremely surprised by that. We are continuing to work closely with Police Scotland, particularly on the work arising from the broader file review.

CARE INSPECTORATE/INTERNAL INSPECTIONS

132. It is worth noting that in relation to Howdenhall the Care Inspectorate reports did not pick up the problems highlighted by Pauline McKinnon's report. There are certainly some inconsistencies in the judgement of Howdenhall by the Care Inspectorate over the time period in question.

133. The most recent ESS report from the Care Inspectorate is dated 6 March 2024. That followed on an unannounced inspection. The ratings for ESS were much improved and the report gives scores of good, although that report was looking at the Close Support Unit rather than the secure unit. At the time of that report, CEC were in the process of separating out the registrations for the separate houses, so that they could receive their own reports.

134. The Care Inspectorate findings for our residential estate are much better now. Those findings consistently say that the children feel loved and happy and safe. We still have some issues with recording in particular. However, those more around not putting things on the right form rather than not recording things at all.

135. I have had conversations with the Care Inspectorate about their methodology. If you speak to children in a setting where they are frightened then they will not tell you that they are frightened. I felt there was an absence of triangulation of the methodology they were using. They need to see children in a safe place. They need to see the social workers and the children's advocate. They need to speak to the parents and see them all individually. They need to get information from the police, from education and from social work.

CULTURE

136. There is an inherent risk with residential care and perhaps particularly with secure care that it can become very insular and develop a closed culture. That is what seems to have happened at ESS and more widely across childrens services. The culture was not properly open to outside scrutiny. Managers who had the opportunity to address problems elected not to address them or did not address them effectively. CEC's quality assurance mechanisms were also ineffective in bringing about meaningful change there. There was a culture of not challenging poor practice. Children's voices were not being heard.

137. The McKinnon report also highlighted specific cultural aspects within ESS. The culture there was not child-centric. Complaints from children were discouraged. There was a macho culture. That involved abuse of power dynamics and emphasised control over care.

138. The Tanner inquiry laid bare some of the cultural difficulties that CEC have encountered over the years. There was a dysfunctional work culture historically in the Children & Families directorate of the social work department. Sean Bell was head of service for that department. I have a staff group who are traumatised by what has happened and this affects them in different ways. We have had to work to find a way to improve our overall organisational culture which has been to bring our focus to what difference are we making for children and how do we know.

139. Although it was prior to my time, the Tanner report highlights a culture of misogyny. There was what was regarded as an "*old boys*" network in the children & families. It is my experience that there is still a lasting culture of misogyny within some parts of the organisation.

140. My own experience is that there are some deep-rooted cultural issues with the social work department at CEC. As a woman who has tried to implement improvements in practice, I have found myself on the receiving end of a number of whistleblowing complaints all of which have been investigated by external lawyers and none of which have found any case to answer. It is recognised by the organisation that I and others who have driven change have done so at significant personal cost.

EXPLOITATION

141. A theme which has arisen from this case study is the exploitation of children when they are in the community and not in secure care. My impression is that the approach to Child Sexual Exploitation ("CSE") in Scotland is not as evolved as it is in England. That is not just within local authorities but nationally.

142. CEC have been working with Action for Children on their Sidestep project. This is a project which aims to divert young people away from getting involved in organised crime. I also provided evidence to Alexis Jay's review into the criminal exploitation of children.

143. In the field of criminal and sexual exploitation CEC started to adopt Contextual Safeguarding approaches formally in July 2022 through a pilot project in North West Edinburgh which ran until June 2023. The Contextual Safeguarding approach has a clear emphasis on the need for practitioners to consider extra-familial risks and harms and risk outside the home. When implemented effectively they complement and strengthen traditional child protection approaches which tend to focus on the management of risks to children from family members within the home.

144. CEC is represented at a national level on the Scottish Contextual Safeguarding Core Group and is active in the Local Area Interest Network which brings together local authorities who are working towards fuller Contextual Safeguarding implementation.

145. CEC ran a staff conference on CSE last year. We have further child exploitation training scheduled for 3 hours on 7 February 2025.

TRAINING

146. I have already discussed that a programme of training was rolled out in relation to restraint. A register containing CALMs training records and a re-accreditation schedule has been compiled. We have also ensured that all residential care staff have undertaken trauma informed training.

LESSONS FROM ENGLAND

147. One area where I consider the English system is better than the current system in Scotland is that English local authorities require to have a Local Authority Designated Officer ("LADO"). This is a statutory role. The LADO is responsible overseeing concerns, allegations, or incidents involving indivuals working with children and young people. Their role involves ensuring that concerns are handled fairly, safeguarding the child's welfare while also ensuring that individuals are not unfairly treated during the process.

148. The LADO does not undertake investigations themselves. They provide guidance on safeguarding and employment law procedures. They oversee the processes to ensure fairness in those processes. They are involved from the outset of a complaint until its conclusion.

149. Another important part of a LADO's role is to spot patterns in complaints or concerns and to instigate further investigation or action if that is considered appropriate.

150. One of the challenges the current team at CEC has had in assisting the inquiry is that there has not been a central point of contact where all investigations and complaints have been retained. For example, it is clear that there was an investigation in relation to St Katharine's around 2000 which resulted in changes to practices. We have not been able to locate that paperwork. There is also reference in the Significant Case Review to an investigation at St Katharine's in 2010 which we have not been able to locate. If a LADO system had been in place, those reports would have been retained and would be easy to find.

151. From my experience south of the border I can see that the rigour of an English Ofsted inspection is much greater than the Care Inspectorate in Scotland. Ofsted see the children on their own. They speak with the parents. They see staff individually. They can put restrictions on practice. They look in more detail at children's records. This system has resulted in circumstances where children have disclosed abuse. Ofsted can also challenge decisions if they think a child is in a care setting that is not right for them.

152. There are pros and cons to that system. There has been a lot of publicity around the rigors of an Ofsted inspection and the pressure that can put upon managers and head teachers.

153. Ofsted would have asked for quality assurance documents. Therefore, if CEC had not been auditing, Ofsted would have picked up on it. After Covid Edinburgh were not auditing.

QUALITY ASSURANCE

154. As part of the Improvement Plan a multi-agency quality assurance group (MAQA) for Children's Services was created. That group has oversight of both registered services within CEC and for services with whom CEC contract. The MAQA mirrors a well-established model of quality assurance in the Edinburgh Health and Social Care Partnership.

155. We have put additional capacity into our commissioning team in order to have an officer who is able to do a monthly unannounced visit and to review and report.

CHILDREN'S VOICES

156. CEC has worked closely with WhoCares? to ensure that advocacy services are available in all residential houses. Another important factor in identifying problems and affecting change is making sure children have effective advocates throughout the whole process. There was a contract with WhoCares? Previously. However they were not as actively involved with the children at Howdenhall as they are now with the children in our houses.

157. CEC also have care experienced individuals participating in our strategic decisions and actively involved in the recruitment of staff.

158. We have now expanded our champions board to three groups - a junior champions board (12-15), senior champions board (15-18) and Seniors+(18-26). These feed into and influence the work of the corporate parenting board. There is a linked participation officer to each of our childrens houses. I meet with the Champs board regularly and have dinner with them.

159. We have opened a corporate parenting hub in the centre of Edinburgh. This is a great resource where anyone who has had care experience can pop in at any time for support, or a chat. It is building a base for the care experienced community in the city that is safe and provides them an anchor.

FAILURE TO LEARN LESSONS

160. As highlighted in CEC's response to the Framework document there is a concerning pattern from the 1990s onwards of a failure to learn lessons from previous inquiries and investigations. In particular, there has been a cycle of abuse, inquiry and attempted but limited and/or not sustained change.

161. In addition to the reports highlighted in the Framework Document response, I am now aware that there was a further Whistleblowing investigation in to practice at St Katharine's around 2000. The concerns raised at that time included similar concerns to some of those highlighted in the McKinnon report. They included concerns over toy-fighting, abuse of power dynamics by male members of staff and inappropriate restraint. There are also similar concerns about restraints not being recorded and children being discouraged from complaining. Raising concerns over practice, particularly outside the unit, appears to have been actively discouraged rather than a healthy work culture promoted.

162. It is shocking to me that these complaints have been going on for such a long period of time at ESS. It is even more concerning that the concerns were raised and then nothing effective was done about them over such a long period of time. .

163. My view is that the reasons why this occurred are multifactorial. The main reasons are due to management failures, inadequate quality assurance processes and cultural issues. CEC has provided further detail in relation to this in our recent Section 21 response submitted in December 2024.

164. There was a clear failure by CEC as an organisation to ensure that the recommendations from the Gordon Collins action plan were implemented in a timeous fashion. I am sorry to say that these failures include a failure by senior managers outside ESS to scrutinise what they were being told and to insist on seeing evidence that the action plan was being followed through and changes embedded.

165. I have no objection to my witness statement being published as part of the evidence to the Inquiry. I believe the facts stated in this witness statement are true.

CONCLUSION

166. CEC will provide closing comments and formal closing submissions at the end of this case study. However, I would like to take this opportunity to apologise to all the children and young people who suffered abuse in our care. They were in our care and we let them down.

167. Personally I feel sickened by the duration and extent of abuse which has occurred on CEC's watch. It is made worse by the fact that CEC failed to take appropriate or effective action to prevent further abuse from happening.

168. It is imperative that this time the lessons are learned and I personally am determined that they will be.

SIGNED.....Amanda Hatton .....

DATED.....17th January 2025 ...