Tuesday, 28 January 2025

(10.00 am)

LADY SMITH: Good morning.

Now, I hesitate to say this, but my welcome today is to the last day of oral evidence in this phase of our case study hearings. Those of you who are astute may remember we began these in September 2023, and we are just completing Chapter 12 of the evidence today. Well done to everybody who's made it thus far, and hopefully today will go well.

We have a witness, Mr Peoples.

MR PEOPLES: Yes, my Lady. The final witness in this chapter and case study who's giving evidence orally is Amanda Hatton.

LADY SMITH: Thank you.

Of course, she gave evidence previously in the Foster Care Case Study --

MR PEOPLES: Yes, she did.

LADY SMITH: -- on I think it was 8 November 2022.

MR PEOPLES: Yes.

Amanda Hatton (affirmed)

LADY SMITH: Amanda, do make yourself comfortable. Sit down. (Pause)

Amanda, thank you for coming back. It's over two years since we last had you here in November 2022 in

our Foster Care Case Study, and I'm really grateful to you for having engaged as you have done to help us with this part of this case study that we've been running since September 2023, as you'll be aware.

You know the form. Your statement is there. I'm really grateful for having that and having been able to study it in advance.

Documents that we may refer to from time to time will come up on the screen in front of you.

A. Yes.

LADY SMITH: If at any time you've got any questions, don't hesitate to speak up.

If you want a break, just say. I usually break at about 11.30am in any event, but if you want a break before then, that's not a problem. All right?

If you've no questions at the moment, I'll hand on to Mr Peoples and he'll take it from there. Is that all right?

A. Yes.

LADY SMITH: Thank you.

Mr Peoples.

Questions from Mr Peoples

MR PEOPLES: My Lady.

Good morning, Amanda.

A. Morning.

Q. Can I begin by asking you to look at the red folder. There is one, I think, there.

I think you have provided the Inquiry in advance of today with a statement, and I just ask you to -- I'll give the reference. It's our reference and you don't need to trouble yourself with it, but it's WIT-3-0000005799.

Could I just ask you to look at the final page of your written statement, page 21, and can you confirm that you've signed and dated your statement?

A. I can confirm that.

Q. You also say on that page that you have no objection to your witness statement being published as part of the evidence to the Inquiry, and you believe the facts stated in your witness statement are true.

A. I can confirm that too.

Q. Now, you've given evidence before, but I think I'll just perhaps briefly run through your background, in terms of qualifications and previous posts and current position.

I think so far as qualifications are concerned, you have a BA and MA in Social and Political Sciences from the University of Cambridge; is that right?

A. Yes.

Q. You are a qualified social worker and have been qualified since around the mid-1990s?

A. 1996.
Q. Yes. Your current position with City of Edinburgh Council since about November 2021 is Executive Director, Children, Education and Justice Services.
A. That's correct.
Q. Previous recent posts in both the public and private sector include Corporate Director of Children, Education and Community Services with the City of York from August 2019 until October 2020?
A. It was until I came to Edinburgh, so it was 2021.
Q. So it's later?
A. Yeah.
Q. I think before then, until July 2019, you had been previously Director of Children's Services for Lancashire from about February of 2017?
A. That's correct.
Q. Before then, you had been Deputy Director of People Services with Blackpool Council from June 2015 until February 2017?
A. Yes.
Q. You also, between April 2014 and June 2015, were Director of Operations for British Forces Social Work?
A. I was, yes.
Q. Yes. Before then, I think you were the managing director of an organisation known as Sector Led

Solutions from September 2010 until April 2014?

A. Yes.

Q. Without going into the depth that you provide in your CV, your areas of experience and expertise include, I think, in particular, social work service and practice improvement?

A. Yes.

Q. Including in the area of children's services?

A. Yes.

Q. Also recruitment and retention of social workers?

A. Yes.

Q. Specialist and contextual safeguarding is another area that you've been involved in?

A. Yes. Yes.

Q. You can tell us about that in due course. I think you mention it in your statement.

A. Yes.

Q. But in broad terms, that does involve -- and, indeed, it is something you've developed -- an approach towards dealing with children at risk of exploitation?

A. Yes.

Q. Your CV indicates that you believe you have a proven record of significantly improving practice.

A. Yes.

Q. Achieving necessary cultural change in the workplace?

A. Yes.
Q. You're someone who places importance on systematic data collection and monitoring of performance of staff and services through regular review and analysis and you're a strong believer in robust audit systems?
A. I am.
Q. So does that capture --
A. Yes. Yeah.
Q. Now, with that introduction, can I move to some acknowledgments that you make in your statement to this Inquiry.

If I could move to paragraph 5 of your statement, you say, and I quote:

'Whilst [City of Edinburgh Council] have issued a formal response to [the Inquiry's] framework document setting out its position, I personally wish to acknowledge on behalf of [City of Edinburgh Council] 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.'

Yes?
A. Yes.

Q. I think you acknowledge -- and I'm going to focus more today on St Katharine's, Howdenhall and Edinburgh Secure Services --

A. Yes.

Q. -- but I think you acknowledge that that is the position also in relation to another establishment we've looked at, Wellington?

A. Absolutely.

Q. Now, you go on at paragraph 6 to say this:

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

A. Yes, absolutely.

Q. If I could just continue, at paragraph 7 you say this:

'I am very sorry to say that [City of Edinburgh Council]'s record in this area is far from good. It is clear that there were a number of missed opportunities for [the council] 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 [City of Edinburgh Council] 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 [City of Edinburgh Council] either being discouraged from raising concerns or not feeling safe when they did raise concerns.'

A. Yes.

Q. Now, against that background -- well, sorry, if I could take it this way: I think, in reaching or making these acknowledgments, you've had regard, I think, to the review of records that was carried out for the purposes of this Inquiry, but you've also had regard to various previous inquiry reports and reviews relating to abuse of children in residential care; is that correct?

A. Yes, it is.

Q. Some of which involved Edinburgh establishments?

A. Yes.

Q. Over the years, there have been a number of important inquiries and reviews concerning the abuse of children in residential care. These include the Edinburgh Inquiry, which reported in 1999, and more recently, the significant case review in 2016 and 2017 following the conviction in 2016 of Gordon Collins.

We have heard evidence at this Inquiry of the findings and conclusions of the investigation conducted in 2020 and 2021 by Pauline McKinnon. I might variously

refer to that as the 'McKinnon report' or the 'ESS report', but you'll know what I mean.

A. Yeah.

Q. Now, one of the major purposes of an inquiry or review is to learn lessons. In the case of City of Edinburgh Council, it's frankly acknowledged, I think, that lessons have not been learned. As the ESS report has shown, many of the systemic issues identified in the Edinburgh Inquiry and in the Gordon Collins significant case review have not been effectively addressed; is that the position?

A. Up until recently, yes.

Q. Well, I'll come to where things are now, but against that background, I think we come to the 64 million dollar question, is it not, in paragraph 8, because you say this:

'Given that history, the question can quite justifiably be asked of whether there can be any confidence that history will not repeat itself again.'

So I think that's the question that you've posed yourself, and I think you're trying to provide an answer that will give reassurance that things are moving in the right direction; is that the position?

A. Yeah, and a significant amount has changed. As I say in my statement, we are not perfect. We are far from

perfect. But we have significant changes in practice, in staffing, in culture, particularly in quality assurance systems and processes. We've got evidence from audits of improvement. We've got evidence from advocacy and Child's Voice of Improvement, which I can go into in more detail as we go through -- as we go through.

I think what's really crucial for me is what we have now is a number of different lenses on practice and a number of different ways to view and understand what's going on in our residential practice and in our wider social work practice. And that's really important, that professional curiosity; absolutely guarding against being complacent and always continuing to ask, 'So what do we know? How can we be better?', is really important. You know, if I wasn't here today, I would be on an away day with my team where we're absolutely doing that. We're doing a review over the last year, what's worked brilliantly and how do we know, crucially, and what do we need to do to be even better?

So, for me, it is about never being complacent, never saying we're okay, never saying we are good enough. Always asking the question about: how do we know what it's like to be a child in our care today and what can we do to be better?

Q. You'll appreciate that it's some time since the submission of the ESS report and, indeed, other inquiries around that time relating to culture and, indeed, the activities of a particular official, Sean Bell, and it's even longer since the Gordon Collins significant case review and subsequent action plan.

You probably heard the evidence of Pauline McKinnon to say: well, this is all very interesting, but we're now in 2025, and just what has changed and what is the evidence of it?

So I think your purpose today is to try and convince her and others that things are happening and have happened since her report. Is that the position?

A. Absolutely.

Q. Now --

LADY SMITH: Can I just interject on one thing -- and I'm sure you'll be coming back to this, Amanda -- you mentioned quality assurance --

A. Yes.

LADY SMITH: -- as being a key factor, and you realised, as you say in your statement, quite quickly that quality assurance processes were not robust when you arrived.

I would be interested to hear from you exactly what quality assurance is --

A. Okay.

LADY SMITH: -- and why it is so important.

Don't bother about it now, but it's one of these phrases that is so easy to trip off the tongue, but I'm getting the impression that it's terribly important to really understand what it is.

A. Do you want me to cover that now, because I can do --

LADY SMITH: No, no, no, because Mr Peoples has a plan.

A. Okay.

LADY SMITH: I'm just being naughty, and that was before I forget, I'm going to throw it into your camp to note to come back to later.

Mr Peoples.

MR PEOPLES: No, I plan to deal with this. It's one of the areas which you do deal with and I'd like a little bit more information too.

A. Okay.

Q. But I'd like to do it in a certain order, if I may. I won't forget, don't worry.

Now, let's just look at what has happened since you arrived in Edinburgh around November 2021.

If we just start at paragraph 10, which is in a section headed 'Overview', you tell us that when you arrived in November 2021, you say you:

'... 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.'

So that's a form of quality assurance, but I'll come back to whether it's the only form and whether there are other systems in place currently.

I think you've probably already answered this question and, as I say, we'll go to it in more depth, but just as a broad question: how important as a safeguarding measure is regular auditing, professionally performed, like Pauline McKinnon, for example, and robust quality assurance systems? How important are these?

A. I think they're fundamental in social care practice. As I said a few minutes ago, it's about: how do we have lines of sight into practice? How do we understand what it's like to be a child in our services? And the only way we can do that is if we have really good auditing, if we have good data, if we've got external advocacy, if we've got a range of different ways that we can understand what's going on for children, if we listen to them, if they've got people that they trust that they can speak to. Otherwise, you don't know what the quality of your practice is.

So I am used to -- and one of the things that wasn't here when I came to Edinburgh is I'm used to an audit

report that goes through a regular dip sample of cases. It's randomly sorted, it has a different theme, it's against a set of criteria, and it's a regular process, because what it does is it catches areas where you need to improve but, really importantly, it also catches really good practice. And I think quality assurance systems need to be seen not as a deficit model; it has to be about finding excellent practice and then building on that and sharing that and making sure we learn from that, as well as learning from where things have gone wrong.

Q. Now, I'll come back, because one of the things that can be a bit daunting for people like me is that there are all sorts of groups, bodies, teams, this and that, and I would like some clarity as to what each does and how they fit into the bigger picture. I'd like to just carry on with your statement at the moment, but I'll come back to the, some of the different teams that seem to emerge from the statement you provided.

But just moving on to paragraph 12 of your statement, which does again touch on this issue of quality assurance, you say when you arrived you:

'... 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.'

So a lot of work to be done in that area?

A. So we now have regular case audits and I get regular audit reports. They are multi-agency and single agency audits, and we've done two fairly recently that relate to children in residential care, both within the city and external to the city.

Reviews are about having a reviewing officer who chairs a review of a child's care plan. When I first came to Edinburgh, the reviewing officers were managed within the service. So, in essence, we were kind of marking our own homework.

Q. So can you just stop there. I mean, when you say 'within the service', the service we're talking about is children's services, is it?

A. Yeah, so --

Q. So where do they sit now?

A. So now they've moved over to the quality assurance section.

So when I came into post, the service director and the Chief Social Work Officer were the same person. Now we've separated those posts, so the service director manages the operations and the Chief Social Work Officer

manages quality assurance as well. So the reviewing officers report directly to her. They don't report to the management of the service anymore. So you've got a separation.

There's also an escalation process for reviewing officers. So if a reviewing officer isn't comfortable with the child's care plan, they can escalate that up the line of hierarchy, ultimately to myself, but typically to the Chief Social Work Officer. It's --

Q. Who's the direct line manager of a quality -- one of these reviewing officers? Who is --

A. So the Chief Social Work Officer line manages the head reviewing officer.

Q. So there's a team leader of reviewing officers --

A. Yeah.

Q. -- and I think you said there's 12 reviewing officers?

A. Yeah.

Q. Historically, they were simply part of children's services --

A. Yeah, they were.

Q. -- and were answerable to Jackie Irvine --

A. Yes.

Q. -- who was both the Chief Social Work Officer and also the --

A. Service director.

Q. -- service director, whereas now you've got two different people performing these functions?
A. Yeah.
Q. Okay. Just again, moving on to paragraph 13, if I may, you also say:

'There were also a lot of people who had worked at Edinburgh for a long time. I considered that 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.'

Yes?

A. Yes.
Q. You go on to deal with what's been done since November 2021 and why you believe you're moving in the right direction, but maybe this is a good enough time to try and get an understanding of what the structure is, to assist us all.

You are, in the current structure, the Executive Director of Children, Education and Justice Services.

A. I am.
Q. You are answerable to the Chief Executive of Edinburgh Council, who is currently Paul Lawrence --

A. He is.
Q. -- who took up position -- was it last year?
A. Yeah, he's been in post for about six months.
Q. Previous to that, it was Andrew Kerr.
A. It was.
Q. Now, below you in the line management structure, you have three service directors.
A. Yes.
Q. You have a Service Director for Performance, Quality and Improvement, who is also Chief Social Work Officer, and that's Rose Howley.
A. That's true.
Q. You've also got a Service Director for Children's and Justice Services, who is Kathy Henwood.
A. Yes.
Q. I think she started in July of 2023 with the council, having come from another authority.
A. She came from Fife. Rose started -- erm, she was temporary and then started permanently just after Kathy. She worked in York prior to coming here.
Q. So these are people that didn't have experience of life in Edinburgh --
A. Yeah.
Q. -- or the culture in Edinburgh before 2023 or thereabouts?

A. Yeah.
Q. Your third service director is Jackie Reid, who's the Service Director for Education and also the Chief Education Officer; is that right?
A. She is, yeah, and she has just been promoted into that post just before Christmas.
Q. Does she have a background in Edinburgh or does she come from elsewhere?
A. She has worked in other authorities. Her most recent post was as a Head of Education in Edinburgh prior to being promoted to this post, but she's worked in a number of different authorities before that.
Q. Okay.

I think that the previous Chief Social Work Officer and also Service Director for Children's Services was Jackie Irvine?
A. She was.
Q. I think she left to join the Care Inspectorate?
A. She did.
Q. So far as these the new recruits are concerned at the service director level, am I right in thinking that after Jackie Irvine left Edinburgh Council in September 2022, Rose Howley was acting up into a Chief Social Work Officer role?
A. She was. She was the interim Chief Social Work Officer.

Q. Before September 2022, what position did she hold?
A. She came to do some work on the quality assurance processes, so she was a head of service.
Q. So she had already been with the council --
A. Yeah. Yeah.
Q. -- but had come from England?
A. She came from York.
Q. York.
A. She worked with me in York.
Q. Okay. So she's someone you knew?
A. Yeah.
Q. At that time, before you sorted out this new structure you've just told us about, which I think was in place by August 2023, you for a time covered the service director role?
A. I did. When we decided to move to a Chief Social Work Officer role and separate it from the service director, Rose took up the Chief Social Work Officer role to have that kind of independent line of sight into practice, and I wanted to see more closely what was going on in practice. So rather than getting another interim as a service director, I line-managed the heads of service directly so I could get a clearer picture of what was going on in front-line practice, and also so I could interview for those new heads of service, because the

heads of service that sit below Kathy's post are all new as well.

Q. Is Kathy Henwood then effectively the Service Director for Children's Services?

A. She is, children and justice.

Q. Well, yes, and justice services, but I'm focusing on children's services today, and below her there are various heads of service; is that right?

A. There are three heads of service.

Q. Who are line-managed by her?

A. Yes.

Q. Are they responsible for children's services and justice services?

A. Three responsible for children's services and one for justice services.

Q. And how do they break down their responsibilities?

A. So we have Karen, who's responsible for the front door and early help and early intervention. She's relatively new. She came from Fife.

We have Janine, who's responsible for, in essence, social work field work, so the locality teams. She was a team manager here previously.

And then we have Steve, who's the Head of Corporate Parenting, so responsible for provider services, i.e. children's homes, erm, and foster placements and

our kind of wider throughcare/aftercare services as well.

Q. Is that Steve Harte?

A. Yeah.

Q. Was he at some point -- for a time, at least -- Senior Manager of Looked After and Accommodated Children?

A. Yeah.

Q. Was that a position he took over when Scott Dunbar, the previous senior manager, was suspended?

A. Yes, he was interim then, and then when the structure became permanent, he was interviewed in a competitive process and got the post.

Q. But he's within the children's services structure, is he?

A. Yeah.

Q. Yes. Another person whose name came up, I think, in the evidence of Pauline McKinnon was Alan McDonald, who was a senior manager, I think, when she was carrying out her review. Is he still with the council?

A. Yes, he works to Steve. So Steve has two managers that run residential. One of them is Alan and the other one is Mark Crawford.

Q. Now, so far as the senior positions are concerned, the service director roles, were all of these individuals appointed by way of a competitive process?

A. Yes, and they were all -- the service directors are all member appointments.
Q. Yes, they're appointed by the council, by a committee of the council?
A. Yeah.
Q. I take it that the process was one of general advertisement; it wasn't just a closed process to City of Edinburgh, it was --
A. No, there was -- for the Service Director and the Chief Social Work Officer posts, we used a national recruitment company. We use GatenbySanderson, who do an executive search. They give you a long list of candidates. We did a three-stage process for those posts. That included a young people interview as well. And then we had the elected member recruitment panel who then make recommendations to full council, and then the appointment is agreed at full council.
Q. Did Rose Howley, Kathy Henwood and Jackie Reid all go through that process?
A. Yeah, Jackie's process had also got a partner panel in it, and we had a technical interview for Jackie's process as well.
Q. So they were all interviewed by the council members?
A. Yeah.
Q. Who was the preferred candidate of the council for the

post of Chief Social Work Officer?
A. Kathy -- sorry, Rose.
Q. Kathy, yes.
A. Rose. Rose for Service Director and Kathy for Chief Social Work Officer.
Q. So they preferred Rose Howley for Chief Social Work Officer and Kathy Henwood for Children and Justice Services Director?
A. Yes.
LADY SMITH: I appreciate, Amanda, that it was a competitive process and outside consultants were involved, but was it part of the council's strategy at that stage to reach out beyond Edinburgh and beyond Edinburgh employees quite specifically?
A. Erm, these are difficult posts to appoint to, so you always want the best person for that post. So whilst you would want to encourage anybody to apply that was internal -- you know, in Jackie's case, Jackie's an internal candidate. You want them to get that post against the best field that is out there. So I think it's really important that it's a -- you use an external agency, if that's appropriate, but that you go through a really rigorous process. And if it's an internal candidate and they get it against that rigorous process, they are clearly the best candidate, and if that's not

the case, then, you know, you've got a candidate from outside.

With the -- with both Kathy and Rose's post, we didn't have any internal applicants for those posts that were permanently here.

LADY SMITH: I wondered whether, having recognised that there was a problem with complacency, there was -- well, let me put it this way: a particular appetite for fresh blood, a new breeze coming in?

A. I think there's always a balance. It's always helpful to have some people who know the way systems and processes work, who know an organisation, particularly who know an area, but it's good to have a mix. And I think, you know, all of our senior team are new into the post that they're in relatively. Some of them have been in Edinburgh a while but in different posts. But they all went through a competitive process to get those posts, and I think that's really important.

LADY SMITH: Thank you.

Mr Peoples.

MR PEOPLES: You tell us Edinburgh used an external agency, but you actually knew Rose Howley beforehand.

A. Yeah.

Q. Did you encourage her to apply?

A. I encouraged her to apply for the Chief Social Work

Officer post, yeah, 'cause she was here as an interim at that point.

I knew most of the candidates that were on the list. I've worked in children's services for a long time, and it's a relatively small world.

Q. Did you have any input into the final selection? You've mentioned the process, but were you asked for your views on any of the candidates?

A. No, the final -- the member process is a member process. So I was there but didn't have a role in the decision-making.

Q. Well, who gives them guidance, then, as to the --

A. Head of HR -- the Head of HR is there, but that's why it's a staged process. So you do the kind of technical interview bit beforehand, so there was an interview with myself, Chief Executive, Head of HR, and then young people's interview panel, and then those that got through that process go to the elected members.

Q. Okay. But I suppose this can be said then, if I understand, maybe not with Jackie Reid, but the other two came from perhaps different cultures?

A. Yes.

Q. Although some of the people that were working under them were part of what one might call the old culture?

A. Yes.

Q. Alan McDonald, for example.
A. Some people have worked in Edinburgh for a long time.
Q. Now, maybe this is as good a time as any to try and work out the various groups and names that you've mentioned in your statement.

We can start from the top. I mean, there's obviously the full council and there's various council committees that are relevant for present purposes, one being the Education, Children and Families Committee within the council, and another is the Governance, Risk and Best Value Committee.

A. Yeah.
Q. I think, in fact, in relation to the improvement plan that you're going to tell us about, that both of these subcommittees are directly involved in getting updates and progress reports on improvement actions and plans?
A. Yes, the Education, Children and Families Committee more so, because they get very regular reports, but Governance, Risk and Best Value also get overview reports, they get audit reports and they get any whistleblowing reports as well.
Q. If we go to the issue of audit or quality assurance and any reviews and reports, to which committee do these reports go?
A. So the Education, Children and Families Committee has an

overview report on the improvement plan and on all the actions that relate to that. They also have quality reports as well. So committee is sitting tomorrow and there's a quality assurance report that goes to committee tomorrow.

Q. What does the other committee do?

A. So Governance, Risk and Best Value is a corporate committee, so that looks at scrutiny, in essence, across the whole council. So they look at internal audit reports, they look at whistleblowing reports, they look at external audit reports. So -- but they look much wider than children's services; they're for the entire council. And also --

Q. Care Inspectorate reports, who looks at those? Care Inspectorate.

A. Care Inspectorate reports would typically go to Education, Children and Families, but any of the committees can remit those reports to another committee, and sometimes they do. So sometimes GRBV will remit an audit report back to the Education, Children and Families Committee and vice versa.

Q. So both committees take a direct interest in, for example, for children's services, issues of quality assurance?

A. Yeah.

Q. What about complaints?
A. Yes.
Q. Both committees?
A. Yes.
Q. Are these standing items?
A. The quality assurance reports are a standing item for Education, Children and Families, yeah, and the members can ask for any other kinds of reports as well and regularly do. So they'll ask for a specific report on a particular topic and we will provide that.

They can also ask for briefings on topics as well. So the committees are all webcast and the papers are in the public domain. If there's a topic that they want more -- to understand more, without necessarily making a decision on it, then sometimes they'll have a briefing on that.

The Education, Children and Families Committee are also -- we're encouraging them to go out more. So members of the committee have been out to visit some of our children's houses, for example. It's a delicate balance, 'cause what you don't want is a committee of people turning up at a house for -- you know, it's the children's -- where the children live. But they have been along to some of our houses as well.
Q. How often do these committees meet?

A. Erm, they're every couple of months.
Q. And do you submit a report to both?
A. Yeah.
Q. For each --
A. Numerous reports, yeah.
Q. Yes, but including reports on the sort of matters that we're talking about here today?
A. Yeah. Yeah.
Q. Now, just another committee which I'd just like to be clear about what its role is in the great scheme of things is the Child Protection Committee, and you mentioned in your statement that currently it has an independent chair, Lilian Pringles.
A. Yes.
Q. Now, first of all, just tell us what the function of a Child Protection Committee is and how it relates to, for example, the full council or any of the component parts of the full council?
A. Okay, so the other committees we've talked about, they are political committees, so they are subcommittees of the council, in essence. The Child Protection Committee is a multi-agency professionals committee, and it is to oversee the appropriate delivery of child protection across the city, so from ourselves as a council but also from our key partners. So, you know, education as part

of the council, but the school role in that, health --

Q. Police?

A. -- police, yeah, and look at public protection.

When I came, Jackie was the chair of that committee, and --

Q. Sorry, I better pause you there. So Jackie Irvine?

A. Yeah.

Q. You mean the Service Director --

A. Yeah.

Q. -- Chief Social Work Officer and chair of the Child Protection Committee was one person?

A. Exactly.

Q. That doesn't seem a great idea.

A. It's not, hence the reason that we've now got Lilian as an independent chair. Lilian is the first independent chair of the committee. She didn't come from Edinburgh. And, again, she was recruited through a process that I wasn't involved in.

Q. Because, I mean, a chair of a committee like that could have quite a lot of influence.

A. Yeah, and should have. She also writes an annual report and the annual report goes to committee. So Lilian's report is on committee tomorrow, the elected member committee. So the Education, Children and Families Committee tomorrow will look at Lilian's report.

They'll also look at the Chief Social Work Officer report as well.

Q. So this committee is, as you say, a committee of professionals.

A. Yeah.

Q. There are no councillors on it?

A. No.

Q. Okay.

What's the relative status of the council and the committee? Are they equals or unequals?

A. They're just -- they're different. They're different processes. So the role of the independent chair and the independent chair's report I think is really important, because when -- the reason that goes to committee is to, in essence, give committee assurance that the child protection processes are where they should be or raise issues of concern where they're not, and that's very much Lilian's role. That's why it's important that she's independent.

There is also the Chief Officers' Group as well, which pulls together the chairs of all the public protection partnerships -- so there is an adult protection partnership in a similar way -- and that's chaired by the chief exec.

Q. There is a process, I think, where there's child

protection concerns, where a referral can be made.

A. Yeah.

Q. Is that to the Child Protection Committee?

A. No, that goes to the front door, so social care direct.

Q. So when you say --

A. That's social work.

Q. To the department?

A. Yeah.

Q. In particular, children's services --

A. Yeah.

Q. -- if it's a children's matter?

A. Yeah.

Q. So the Child Protection Committee don't deal directly with referrals?

A. No, they don't, but what they do do is they look at the data that relates to the flow of work through the child protection system. So they look at number of referrals, they look at number of IRDs, which are --

Q. Could you just give us what the acronym stands for?

A. So that's an interagency referral discussion. They look at --

LADY SMITH: Sorry, can you just give us that again a little slower?

A. Interagency referral discussion.

LADY SMITH: Interagency referral, thank you.

A. Yeah, or initial referral discussion, it's used interchangeably. It's -- in essence, when you've got a concern about a child, it's -- the professionals would come together and have a discussion about, 'What do we do next and what needs to happen next?', and then develop that initial plan.

Q. You say 'the professionals'; just again so we're not unclear about this, the professionals that come together for this interagency referral discussion, which could be one or more meetings, are whom?

A. So that's ourselves and the police, health colleagues as well, and increasingly education colleagues now.

Q. Right, so this is a multi-agency --

A. Yeah.

Q. -- discussion, a matter having been referred as raising a child protection concern --

A. Yeah.

Q. -- and the function of this discussion is to determine how the matter should be dealt with --

A. Yes.

Q. -- and whether it should involve, for example, a police investigation or some other form of action --

A. Yeah.

Q. -- either by the police or social work or health or whatever?

A. Yes.
Q. So they really regulate how these matters go forward?
A. Yes.
Q. So that's not a social work decision; it's a decision collectively taken?
A. Yeah.
Q. Okay.

Now, we've got the Social Work Department of the council, and are you Head of the Social Work Department?
A. No.
Q. Who is?
A. So Kathy is the service director, so she's the leader of the Social Work Department. Rose has the statutory responsibility for the quality of social work.
Q. So are you not technically within the Social Work Department?
A. No.
Q. You're above that?
A. Yeah.
Q. So the department is a component, but you sit higher than that?
A. Yes.
Q. There are other bodies, and I just want to check where we are with these.

You've mentioned, I think, during the course of your

statement, a Quality Assurance Team. So is there a Quality Assurance Team or service or department?

A. There is. It works to Rose. So Rose has the Reviewing Officer Team, but then she also has a Quality Assurance team and she has a Learning and Development Team.

Q. Is that team currently headed by an individual who was Pauline McKinnon's line manager?

A. It is.

Q. A person that I think she had some concerns about in the past?

A. It -- she did.

Q. But he's still in charge of Quality Assurance?

A. He is. He manages that team.

Q. Is that a team of four?

A. Yeah. We've also, erm, brought in additional capacity into that team at points. So when I first came, we brought in a team of external auditors to come and do some of the audit work. Because there hadn't been case audit work done for such a long time, we went outwith the organisation, brought in a team of agency auditors, and where we feel we need to look at practice in more detail, then we will continue to do that.

Q. So this Quality Assurance Team that sits under the Chief Social Work Officer in this new separate role is headed by this individual, and under him are a team of four --

can I call them Quality Assurance Officers?
A. Yes, that's what they are.
Q. One of whom is presumably the replacement for Pauline McKinnon?
A. Yes.
Q. The other three, were they in post at the time she was doing her review of ESS?
A. Er, yes, I think they were.
Q. They are quality assurance officers, and did they include Heather Smith?
A. Yes, Heather's still here.
Q. And she's still in that role?
A. Yes.
Q. And their function is from time to time to carry out audits?
A. They support -- they carry out audits, but they also support the managers to undertake audits as well, and they act as a kind of moderator on management audits.

So what you would expect typically in social work is that managers audit cases routinely and that quality assurance officers also audit cases, and that the quality assurance officers will then dip sample any cases that a manager audits to make sure that you've got a moderated process.
Q. So one of the functions of a senior manager of a service

or a manager of a service is to carry out audit functions?

A. Yeah, absolutely.

Q. But they also have this separate audit team who can step in or, indeed, carry out their own audit and make judgments on --

A. Yeah, and we also have the Internal Audit Team who sit outwith my directorate, who periodically will do audits of various aspects of our practice as well.

Q. So the Quality Assurance Team we're talking about here is different from the Internal Audit Team, which is a council-wide team?

A. Yes. Yeah.

Q. They too can presumably oversee the Quality Assurance Team if they want?

A. And they do. So one of the things that -- internal audit is a proportionate process, so one of the things that they will do is look at the quality assurance processes. If they feel that they're proportionate and appropriate, then they will look at different aspects in their audit -- in their annual audit plan, and they'll act as a critical friend as well on our early processes.

Q. You use this term 'critical friend' a couple of times. Is it a term you use as a term that's -- a recognised term? Has it got some form of significance or status?

What's a critical friend?

A. It's somebody who would understand your service, but would give you a slightly independent eye into your service.

So we will sometimes -- if there's an area that we're not sure about, we will ask Internal Audit to give us a view as to whether or not, for example, they think the evidence that we've got for a change is robust enough. We'll ask them to come and look at particular aspects of service that we want a detailed lens in.

So at the moment, for example, they're looking at the GIRFEC, which is the 'Getting it right for every child' process, to look at how we're working as a group of agencies on that early help offer.

Internal audit reports go to Governance, Risk and Best Value Committee, but that one will also go to Education, Children and Families Committee as well.

Q. We can see there there's a Quality Assurance Team that sits under the Chief Social Work Officer, and you told us that the 12 reviewing officers, including the team manager who heads up these, that that group are part of -- or are line-managed by the Chief Social Work Officer, but are they a separate team from the Quality Assurance Team?

A. Yes. Yes. They work closely together, but they are

separate teams.

Q. Yes, but they both report up to the Chief Social Work Officer as their line manager, effectively?

A. Yes. Yes, and there's also a Learning and Development Team, which is a new team and an expanded team. So the idea being the way it works is that the Quality Assurance Team and the Reviewing Officer Team identify areas of good practice, and the Learning and Development Team share that learning, but they also identify areas where we need to develop, and the learning and development team then put on a whole range of different learning activity so that we're kind of continuing the loop -- the learning loop.

Q. And who's doing things like trying to keep abreast of current best practice and research developments and social work changes?

A. That sits in that bit of the world.

Q. The Learning and Development Team?

A. Well, in the quality -- in Rose's bit of the world generally. But, erm, yeah, in Learning and Development.

So Brenda-Anne, for example, who heads up the Reviewing Officer Team --

LADY SMITH: Sorry, who was that?

A. Brenda-Anne, who heads up the Reviewing Officer Team, she chairs the National Reviewing Officer Network, so

she's very involved in best practice in that area. She's been very involved in the production of a National Reviewing Officer Handbook, which is kind of enshrined in some of the changes that we've brought in around a stronger voice for reviewing officers, reviewing officers developing a relationship with the children that they work for so that they're able to advocate for their children.

Rose goes to chief social work officer groups, which again brings the chief social work officers together.

Kathy's very involved in a number of networks, particularly interested in child voice and participation, and has brought together numbers of external experts to deliver presentations and conferences in the city.

So we're keen to be involved in being outward-looking and looking at best practice. Residential services worked with Aberlour and Kibble around becoming a no-restraint organisation. So we're very keen to do that.

We've just taken part in a thematic review with the Care Inspectorate. They asked for volunteers, and we volunteered to be part of a review to look at our Throughcare and Aftercare Service.

Q. Now, can I come back to some of these things you've told

us about so we don't lose track of where everyone is and what they're doing.

You've told us that reviewing officers are 12 in number and the Team Manager is Brenda -- is it 'Ran'?

A. Brenda-Anne.

Q. R-A?

A. Brenda-Anne.

Q. Anne?

A. Cochrane. Yeah, Brenda-Anne is her first name.

Q. Oh, sorry. All right. And she's the Team Manager you've told us about.

A. Yeah.

Q. I think you tell us in your statement that the current function of reviewing officers includes reviewing care plans for children who are looked after, including in residential settings.

A. Yes, yeah.

Q. But they are not the people that are directly involved in the care planning for that child; this is an independent review, is it?

A. Yeah, so children's care plans are reviewed regularly, and that review involves the professionals that are involved in that child's life.

LADY SMITH: Sorry to interject. Is this what you're dealing with at paragraph 48?

MR PEOPLES: Well, it could be, but I --
A. I can't see paragraph 48.
LADY SMITH: It'll be coming up.
MR PEOPLES: Yes.
A. Yeah.
LADY SMITH: Yes, right. Thank you.
A. So they would -- the family are involved in reviews and, crucially, the child's involved in reviews. So it can be a single meeting, it can be a series of meetings, and it is to look at the care plan, to make sure it's achieving the outcomes that it's supposed to be achieving. It's to ensure that the child is getting all the support that they need. It's also to look at, as children are moving out of our care, to look at transition planning from our care, and look at the quality of the plan as well.
Q. So do they take a sample?
A. They review every plan.
Q. Every plan?
A. Yeah. So every child has regular reviews chaired by a reviewing officer.
Q. How often?
A. It's at different points in time, depending on the length of time that they've been in care. So typically you'd review it one month, if it's a new placement, then

three months, then six months, and then after that it's typically six-monthly. But some children that are in a permanent placement and they've got permanency orders may well go slightly less than that. So they might go to a kind of annual review process.

Q. Are these statutory time limits for review?

A. They are -- there are some statutory time limits, but the kind of permanence limits are variable, depending on what's right for the child.

Q. We know, I think, from other evidence that we're now in the era of care planning, and that was a requirement of regulations and that children have to have a care plan, and it has to be reviewed on a regular basis to see that it still meets their assessed needs.

A. Yes.

Q. That's the general, I think, idea behind the whole process.

A. Yeah.

Q. Just on this question of what the reviewing officers do, they review these plans and there are meetings involved, and these meetings have children present?

A. Yes. So --

Q. And others, like their key worker?

A. Yeah.

Q. The social worker? Their allocated social worker?

A. Yeah. Yes.
Q. And other people?
A. Yeah. So families are typically involved in reviews. A lot of our reviews we have Who Cares?, so they're an independent advocacy service. They would come along with the young person.

It's basically the people that are important to a child and are important to delivering the care plan. So, you know, depending on what that child is doing educationally, it may be different people. If the child's got therapy input, then the therapist might go along to that service -- to that review.

So typically you'd have family, social worker, education, health, and then other people that are important in that child's plan.
Q. I mean, is there a problem of getting everyone together for meetings? Is that a real problem, that you don't always get the people you want?
A. It's easier post-COVID, because sometimes we do hybrid meetings and we're more used to doing that now. We will sometimes do a series of meetings.

So in our most recent audit, 84 per cent of children went along to their review, but we've got consistently around 10 per cent of children that don't go to their review. Now, some of them are too young; you know, you

wouldn't expect a baby to go along to their review. But for some young people, that's quite a daunting place to be, to sit in a room with a lot of other professionals. So sometimes we'll do a review meeting that's two meetings or multiple meetings.

So I would expect the reviewing officer, and the reviewing officers do now, offer to meet children outwith that review process, so they're building a relationship with them.

Sometimes it's difficult for a family to be part of that bigger review meeting. So, again, you might do a series of meetings, rather than just one meeting.

Q. You tell us, I think, in your statement that one of the responsibilities or functions of a reviewing officer -- who is a social worker.

A. Yeah.

Q. A senior social worker?

A. Yeah, they're very experienced social workers, typically.

Q. One of the functions is that they're expected to call out poor practice.

Now, I'm just wondering, that leads me to the question: how do they actually do that in practice? Is it based on looking at the plan itself? Is it based on what's said at the meetings? Is there other ways in

which they identify poor practice? How do they do it?

A. So they would look at the care plan initially. So you would expect a care plan to be very clear about what it's trying to achieve and very clear about how you'll know when you're there. So you'll hear lots of reference to smart targets. So you should be really clear in a care plan, you know, what an outcome looks like and how you're measuring that outcome, and if that isn't there in a care plan, then a reviewing officer should be raising that and saying.

So it might say things like, you know, 'Child X should engage with education'. Well, that doesn't really mean anything. You know, so what you'd expect in a care plan is, 'Child X will attend placement Y on these dates and be supported to do that in this way, and if that doesn't happen, then this is the contingency plan'. That's a good care plan. So a reviewing officer would look at that.

Part of the review process is working with the professionals and the family and the child around: is that plan working? Because, you know, people's lives change, situations change, and a plan should be very much a live document and a dynamic document. So it's checking out: is it working?

If it isn't working, then it's making sure we've got

contingency plans around: why isn't it working? And it's a reviewing officer's role to make sure that that happens in a timely way and that there isn't drift and delay in that plan.

Q. How do they know, though? I mean, if a care plan says that certain things are needed for this particular child and that a particular establishment has been chosen to try and meet those needs, how does the reviewing officer work out, in practice, whether those that have got direct responsibility for delivery of the plan are doing what the plan asks them to do?

A. Well, they'd be asking the child. You know, that's really important. Part of the review officer process we have now is that they meet the child outwith reviews. I'd expect them to go and see a child in placement. Erm, the social worker should be visiting the child regularly in placement, so the social worker would have a view. The house that the child is in or the carer that the child is with would have a view, as would the other professionals in the room. The family will have a view, and increasingly in our residential houses, we expect the family to be in the house as well. So families are much more involved in those houses, see the houses outwith those review processes.

We also have independent advocacy as well. So

Who Cares? are regularly involved in reviews, regularly in our houses, and they would have a view as to whether or not this is working.

Q. Do the reviewing officers themselves go and visit the establishments --

A. Yes.

Q. -- as well, to form their own impressions?

A. Yeah.

Q. Okay.

You've told us that now -- and I think this is something that wasn't in place before November 2021 -- there is a way of escalating, to use that expression, issues and concerns, and that there's a process whereby it can reach the Chief Social Work Officer and, indeed, beyond, if the issue requires it to?

A. Yeah.

Q. That's a formal process that didn't exist before?

A. Yes.

Q. But you said the role of reviewing officers, apart from being moved away from the service itself into quality -- or into the same line management responsibility under the Chief Social Work Officer, you said that the whole role has changed significantly in the last five years.

What I'm wondering is: well, what were they doing before then?

A. I think they had less of a defined role before then. There was less clarity about -- that they are a sort of semi-independent voice for children. There was less clarity about: it is their role to be -- that 'critical friend' term again.

They were raising issues around care planning. They were raising issues primarily about drift and delay. That's often one of the areas that reviewing officers raise issues. But it was easier in that system for those concerns not to be heard, because they were managed by the same teams, and there wasn't a process of capturing that.

So now there is a process where if a reviewing officer raises something, they can raise it formally. There is -- we have many spreadsheets. There is a spreadsheet where that's logged and actions are reviewed. If that -- if the actions that have been required aren't moving forward enough, then that's where there's an escalation process, and ultimately they will go to Rose, who would then make a decision, make a direction, in relation to a child's care plan.

Q. Whereas previously, I suppose, the reviewing officers, if they didn't sit outwith the service and were raising these issues, were raising them in a way that might be a criticism of the service and the people heading it,

and yet the people heading it are the people that are managing them?

A. Yeah, which is why it -- you would want a reviewing officer service and a social work service to work together, because everybody is there to get the best for the children that we work for, but there is a dynamic tension between the two services as well, and there should be, and they're managed -- them being managed in a separate line-management arrangement means that you have got more grit in the oyster, if you like. You know, you've got that separate set of eyes that aren't actively involved in the day-to-day management of that case.

Q. Okay.

A. And that's really important.

Q. I'm just wondering, obviously people can -- so far as youth offending, you have youth offending services within the council.

A. With the Justice Service, yes.

Q. That's in Justice. But would they mainly be concerned with cases which might involve young people from Edinburgh going into some secure setting or not? No?

A. No, they would work primarily with children that are either on the edge of or in conflict with the law. So that's -- they would work with children that are in

a secure setting, but that's a very small cohort of the young people they work with.

Q. Okay.

You tell us that one thing that was, I think, a new development since November 2021 is the establishment of a Corporate Parenting Team headed by Emily Dempsey. That's paragraph 46, I think, of your statement.

A. Yes.

Q. Just explain the thinking behind establishing another team, and where does it sit?

A. So this team sits within service, so it sits within Steve's bit of the world -- Steve Harte's bit of the world. So this is a Participation Officer Team. So we have Emily and then we have three participation workers, one of whom is care experienced, and they run the Corporate Parenting Hub, which is also new.

So the corporate -- when I first came, one of the things that the young people were saying a lot was that they didn't have anywhere to meet as a care experienced community, and they didn't have anywhere that was theirs, and they very much wanted a city centre premises in which they could meet and be together.

So we worked well together as an entire council to identify a building, which is on Leith Street, which the young people then designed how they wanted it used, what

they wanted the furniture to be like, what the rooms are like, and it's very much their space. The idea is that it's a home from home. So it's for any young person who is care experienced in Edinburgh, and they have always got a place that they can come back to.

It's got meeting rooms, but it's also got really nice informal space. It's got space where children can have family time. So if they want to -- if they're meeting their siblings, that isn't in a place that feels like a social work office. It's going to have a kitchen and a large area where we can eat together. So it's got a small kitchen at the minute, but it's going to have a much bigger kitchen, because the Champions Board -- so that is the children in care's board --

Q. Well, don't go into the Champions Board yet.

A. Well, they also meet there as well and they're supported by that team.

So that team is very much around making sure that children and young people who are part of the care experienced community can build links in that community, so they can meet other care experienced young people.

The participation workers are linked to the houses as well, so our children's houses, so make sure that they're in those houses and young people know their rights, young people know that they can access the

Champions Board and they can access support.

Q. So just stopping there, the young people in the houses, do they have access to the Corporate Parenting Hub as well?

A. Yes. Yeah.

Q. So they're meeting people who have been in houses perhaps before, they've got a chance to engage with people that have been through the system and maybe in the same places that they have been?

A. Absolutely.

Q. You say there's meeting rooms; is that an opportunity for either the young people in one of the houses or other people to raise issues with the Corporate Parenting Team?

A. Yeah, absolutely.

Q. Yes.

A. Yeah, and I -- so that's where the Champions Board comes in. So there are three Champions Boards, and they basically relate to different ages of children and young people in care, and that's drawn from the whole care community. So it's people that are in residential care, it's people that are in foster care, people that are in kinship care, young people who've been adopted, and then they meet regularly with decision-makers, as they refer to them.

So I meet very regularly with the Champs Board. We have dinner together on a Thursday night and they're very involved in things like service reviews. They're -- they did a presentation on what they wanted a throughcare and aftercare service to look like, which prompted the service review, and they meet at the Corporate Parenting Hub.

Q. Do they represent young people, both who are currently in care and who have been in care, to present ideas or views on improvements or proposed changes or, indeed, existing systems? Is that their function?

A. Yeah, it is. They're not the sole voice of children and young people in care. So, you know, messages through the reviewing system, through advocacy, are also really important as well, 'cause they're quite small groups, but they are there to support children and young people in care.

They are also establishing a peer mentoring system, which picks up more of what you referred to before about particularly for young people who are new into care, having somebody who's experienced the care process that they can talk to and they can link with that isn't a professional.

You know, it's really important that young people have professionals that love them and care for them in

their lives. But, you know, as we were saying before, I'm 54; you know, a teenager is not going to expect me to understand their life in a way that they would expect another teenager or another young person to understand their life. And increasingly, the care experienced community sees itself as a community, and they want places where they can share that experience with other people who are care experienced.

So the Corporate Parenting Team are working on the peer mentoring programme with a group of young people so that they can have access to that as well.

Q. So it's a sort of forum that they can use to convey views on a range of matters, including existing systems and arrangements, and proposed changes to those?

A. Yeah, absolutely.

Q. And comment on any developments proposed and so forth.

I just wonder, though, those that are on the board of the Champions Boards, I mean, how are they selected?

A. They're very much self-selected. So young people come forward to say they want to be part of the Champions Board. That's why we now have three different ages of Champs Board, to try and encourage young people to be part of that.

Typically what we do is we take groups of young people that are interested away so they can get to know

each other. So we have Lagganlia, which is one of our outdoor education places. It's up near Aviemore, it's great. So we typically go once a year with any young people that are interested and do a kind of week of Outward Bound experiences with them, and then they start to kind of get to know each other as a group, they get to know us as officers and individuals, and then they make the decision as to whether or not they want to be part of that Champs Board going forward.

Q. Are there three boards?

A. Yeah.

Q. And so they meet separately?

A. Yeah.

Q. And they're divided into ages?

A. Yeah.

Q. And are they all currently in care?

A. Yes -- well, some of the senior Champs Board, so the older group, they've moved on, some of those young people. So some of them are in continuing care and so are still living in their placement even though they're older, and some of them are now semi-independent or independently living. It's a mixture.

Q. I suppose, like members of parliament, you might ask yourself: well, how do the board members ascertain or collect the views of the community they're representing?

How do they find out what other young people think on the issues that they contribute to? I mean, is there some way that they meet with their constituency, if you like? How's that done?

A. They do a different -- yeah, they do a range of different ways of doing that. So they'll run events. So they'll run events at the Corporate Parenting Hub. They use QR codes to get feedback from young people. They'll link to the houses. So one of the previous participation officers who's moved on to another role now, she had previously lived in one of the houses, and she then went back and did a review of that house for us. They meet with the young people in the houses as well. So there are different ways that they kind of support other young people.

But that's why we don't say they are the representative voice of children in care, 'cause they can't be. They can't be the only voice. That's why we need things like, Who Cares? That's why we need reviewing officers. That's why we need, you know, young people involved in their reviews, so that we've got all those different voices.

Q. I mean, in terms of another way of getting feedback of the views and experiences and feelings of young people currently in care, what are the other mechanisms? For

example, are young people in your houses regularly asked for feedback, and how is that done?

A. Yeah. So in different ways. Again, we use the QR codes.

Who Cares?, who are the independent advocacy organisation, go into all of our houses and have links in our houses, erm, and they're available to young people who are there.

Young people make representations through their carers as well. They make representations through their families very often. They -- which is why it's really important that families are part of houses as well.

So I think that's been another real change in culture, that what all of the houses do now is have events where they're much more open. So I've been to barbecues at Drylaw, for example, where families come along to the barbecue, as do people that -- young people that have lived there previously. They come back. You know, like we would have with our families, we'd have a family barbecue, that's what they do.

They also invite elected members along to those barbecues so, again, young people can speak directly to elected members. I go along; they can speak directly to me.

So there are lots of different avenues that young

people's voices can be heard.

Q. And how is the -- if I could use the expression -- data collected and stored and then analysed and reviewed?

A. So we get -- the information that comes through reviews, it goes into our quality assurance processes. When we do audits, we talk to young people as well, so that goes into our audit plans -- our audit reports and then into our improvement plans. The Who Cares? reports come to one of our quality committees and then come along to my performance committee. So, again, anything that's in a Who Cares? report that says we've got an area of practice that we need to improve here, we'll come along to that committee, and then we'll have an action plan that relates to it.

Q. But, for example, we have seen an example of an attempt to do a survey on young people in 2010. It was a small survey, seven people, but they expressed views and there was a summary of it in a document I don't need to take you to. But is there a way of capturing, recording, the direct voice of the children, not just simply what someone reports as having been said or summarising the gist? Do you have a means to get that, to hear straight from the child?

A. Yeah. I mean, children and young people being involved in their reviews is really important. So, you know,

84 per cent of children going to their review really is key to that.

We do -- we record children's information as they would want it recorded on their file as well. We're moving -- we're changing the recording system. So we've currently got SWIFT, which is an old -- very old system, and it's not a particularly helpful system to store children's physical information on. We're moving to Mosaic. So on Mosaic you can upload things much more easily. Children can upload information directly onto the system.

So, for example, if you were doing a piece of work with a child around life story work, quite often, that doesn't typically sit on an electronic system, because for most young people, their life story work is a book that's got lots of important -- it's got photographs in it, it's got important letters in it, it's got -- you know, some children have things like, you know, the band that you have when you're born on your wrist. It goes -- it's like a memory box, and it's really important. That's difficult to kind of physically represent in a -- in the current system that we've got. In Mosaic, you can scan that in differently. There's a digital vault that goes in there.

One of the other things that's typical in a kind of

Mosaic workflow system is a bit that sits at the front of a file that says, 'What do you need to know to work with me?' So that's very -- that's the young person's voice in the file right at the beginning. Typically we'd have photographs of young people on that file. So it becomes much more theirs.

It's also easier to input onto it. So once a new system comes in, and we're just implementing phase 1 now, you would expect a social worker and a reviewing officer to be sat with a young person with a digital device and them input directly onto that. So it's very much a joint record.

We do capture increasingly where we've had discussions around young people's lives on their file. So previously supervision was kept in a supervision file, not on the young person's file, and audits weren't on the young person's file. Now they all are, so that if a young person is having access to their file, they can see what professionals are looking at, what professionals are concerned about, what they're not concerned about.

Q. Because I think historically, one criticism that was made, I think maybe in the McKinnon report, was that finding information on a complaint and how it was dealt with and the outcome and the nature of any investigation

was a very difficult task, and there was no one place to find it.

A. Yeah.

Q. You're suggesting to me that once Mosaic is in place, all the information --

A. It will be.

Q. -- about a child of the descriptions that you've mentioned will be in one place and accessible easily. Is that what you're telling me?

A. Yeah. So Mosaic is a workflow system. So, in essence, it takes you through a journey -- a child's journey through a system. So you'll have the initial contact with that child, you have case recording, you have all of the reviews, you have all of the assessments. It's a live system that walks you through, and it's a very well-used system in social work. It's a very intuitive system to work. There's a complaints module on there as well. So if there are any complaints, they would automatically go directly onto the system.

And because it's a workflow system, you don't typically email information to each other. So if somebody wants to report a concern to me, they wouldn't do it via email; they would do it within the system. So you can see the date it's been sent to me, you can see the date that I've read it, and you can't remove things

from the system, because --

LADY SMITH: Amanda, how are you alerted to a message?

A. So you have, like, a work tray that comes in, and so -- it will know whether I've responded to it, and you can't take things off the system.

So everything that's on the system is date stamped. So if I were to go into a record in SWIFT now, for example, you wouldn't know that I'd been in that record. If I was to go into a record in Mosaic, you would be able to know that I'd been in that record, what I had changed in that record, how long I'd been in that record. You can lock records down. So it's a more secure system.

And it's also a much easier system -- if you're a young person who wants to make sense of your life and you want access to your records, it's a much, much easier way to go through your information.

MR PEOPLES: Whereas we were told in evidence that, obviously, there was some evidence suggesting that key documents to do with incidents or complaints may have undergone alteration.

A. Yeah.

Q. Are you telling me that the way that these would now be recorded from start to finish would not permit that, or you would see the alteration if it happened?

A. Yeah. Once Mosaic is in, in order to make any changes, you can see that the change has been made 'cause everything is date stamped. If anything needs to be -- sometimes people make a mistake on a system and record the wrong thing. In order to change that, you have to do something that's called a rollback. So, in essence, you have to roll back to the point that that information was put on, change it, and then put all the other information back, and there's an audit trail of all of those actions. So you can't just delete something on Mosaic.

Q. When is this system going to be rolled out?

A. So it's -- phase 1 is coming out now, which is starting to migrate the basic information. So we're doing that at this point in time, and it will be live across the whole piece next year.

So it's not a quick process. Erm, it's a complicated process. Obviously, we've got thousands of records that we have to move across. We have to make sure we do it right. But we've got a whole team working on it.

Q. That will move over historical records as well that were on SWIFT?

A. So we're going to do new records initially, and then we're going to move over a proportion of historic

records, because obviously if a child is still an open case, you need to understand their history, so you need to have access to their records.

Anything that's historic and closed, we're looking at how we're going to -- what we're going to do with that, but it's likely that that's just going to be digitised and put in a secure vault.

Q. Yes, because you are now, under current legislation and rules, required to keep information about children for quite a lengthy period of time; is that not correct?

A. Yes.

Q. Whereas before, I think, it wasn't that way. I think the significant case review pointed out some of the differences between the historical situation and the current one, which perhaps explained loss of records in the past, but that shouldn't be the case now?

A. It won't be.

Q. The other thing, though, of course, with any system -- you need a good recording system, and you say you're going to get one with Mosaic that will replace the SWIFT system. But, of course, a system is only as good as the information that's put into it.

A. Yes, of course it is.

Q. So if the people that have to put in key information don't put in adequate or full information, particularly

on incidents, for example, or significant events or complaints or restraints or whatever, then you can have the best system in the world, but it's not going to help you much if the people who are required to input are not doing their job.

So how do you ensure that that is the case?

A. So that's where things like audit, data, management oversight are really important.

The thing that I'm very excited about with Mosaic is it gives you really, really good performance information out of the back of it. At the minute, to access -- to kind of get workflow information for us is quite difficult, and we've got a lot of different systems that -- and it's labour-intensive. Once we've got Mosaic in, I'll be able to log on to Mosaic and know how many cases I've got, who's got an up-to-date assessment, who's got a care plan that's coming to an end, when a child was last visited. It's all very live. So the quality of the information that you can access is much better.

So I'll be able to look on a case and see that a child who's maybe in secure wasn't visited within acceptable timescales, so I can -- so I'll pick that up.

Q. Would you be able to pick up quite quickly -- you or perhaps a reviewing officer or a quality assurance

officer, would be able to pick up quite quickly whether particular individuals are making an adequate record?

A. Yeah.

Q. And they can pull them up, if necessary?

A. Yeah. So --

Q. Or train them?

A. So audit looks at that. Audit looks at case records and we do a dip sample of case records. Because it's a workflow system as well, you can also lock down bits of the system. So you can't move to the next bit of the workflow unless somebody -- it is called 'outcoming' -- unless somebody has outcomed that step. So that's typically unless a manager has gone in, looked at that record, agreed that that's an appropriate action and put a case note on file.

Now, we expect managers to do that now and we do review that in audit, and we know that our management oversight is much better. So the last audit, I think it was about 68 per cent improvement in management oversight being on file.

But it's not -- I can't pull off now a report that says how many cases have had management oversight in the last month. From Mosaic, I'll be able to do that. So I will know where the checks and balances are, as will everybody else in the organisation.

Q. Because I think Pauline McKinnon said that when she tried to find information -- I mean, apart from the fact that a lot of it was in boxes and not in an electronic system, but she did have access to SWIFT -- she did say that it was often virtually impossible to work out just who did what and when, and what investigations there were and what outcomes were and the reasons for the outcomes.

Are you saying that this system, the purpose is to see that all of that can be quickly ascertained if need be?

A. It's part of the answer. It's not the whole answer.

Q. No.

A. You know, so the other thing that we now have is we have practice standards; so, you know, where we expect certain things to be on a file, we expect certain things to be updated within specific time periods.

We have a record, a monthly report that comes in that says -- so, for example, says how many cases have had management information put on within -- management oversight within the last 12 weeks, how many have had a case record within a set period of time.

So -- but it's hard to get that information at the minute. From Mosaic, that is much quicker.

Q. And once that is possible with Mosaic, who's going to be

doing this sort of checking to see that targets have been met, the plans are appropriate, recordings are appropriate, there's an analysis of general information to see if there are any trends or patterns about, for example, the use of restraint, if it's being used and so forth? Who's doing that bit, the analysis and review exercise? Whose responsibility is that?

A. So it's done at different levels. So on a team level, that would be common in team meetings, that you look at that, you look at performance information, you look at your performance data, and then that works up all the way through the organisation. So a team leader would be -- with their team of social workers, would be looking at their basic key information, so how many visits are in timescale? Who's got a care plan that's in timescale? Have you got assessments that are coming towards the end of their period and they're not written up yet? Have you got cases that need to be closed that are still showing on the system? So they do that kind of check, and then that happens at different levels.

And ultimately, I have a monthly performance meeting where we go through those kind of key overarching areas, and if there's an area that I don't think we've got evidence of, then I'll either ask for a specific audit or a specific report to be done on that area.

Q. Because one thing that Pauline McKinnon's exercise revealed was that she looked at records over a period from 2008 to 2019, and they were existing records, not necessarily complete, but by doing it in a very thorough, systematic and methodical way, she was able, from the records, even without evidence of direct disclosures by staff or children, to detect patterns and indicators of abuse or possible abuse or ill-treatment or bad practice or inappropriate restraint and so forth, and she said, of course, I think, that inspectors who come in for snapshots perhaps don't have the ability to do that exercise as she did.

But is that going to be a feature of Edinburgh going forward, that someone will be doing the Pauline McKinnon exercise? Not just looking at the last month or the last two months, but over time, whether a year, two years, five years or whatever? Is that in place?

A. It is a feature of Edinburgh now. So since Pauline's report, I've commissioned two further reviews of historic files, one of which continues. So we've reviewed -- we've done 70 full case reviews of historic files, erm, and we've looked at 280 plus files that relate to historic information.

And there are layers of audit. So there is a monthly audit, which is a thematic audit. So, you

know, we'll look at, for example, children who are in external placements, or we'll look at children in kinship care. But then there's also the kind of routine audits. So we do a regular audit of cases that come into the front door of social work, and they're all random samples.

So what we don't do is say to Kathy, 'Tell us which cases you want us to look at'. What we do is we say, 'Here are the case numbers of the 20 cases that we're going to look at'. And because we pull all of that together in a learning and development plan, then that does pick up themes.

But, again, it's only one lens into practice. You know, audits are really important, but it's really important that you triangulate that with data and you triangulate that with what children are telling you and what families are telling you.

Q. I think she was trying to get the bigger picture, and she was using largely records because she didn't interview people.

A. Yeah.

Q. You say that that's an extra layer that you can put in to get it, but you do need to look at the bigger picture over time, because it would appear that Edinburgh Secure Services were getting pretty reasonable Care

Inspectorate reports over the piece, but yet when you do this exercise, a very different picture seems to emerge.

Now, that doesn't suggest that the current safeguards work effectively to uncover bad practice or evidence of abuse, because very few people -- I think as the SCR found for Gordon Collins -- very few children disclose abuse directly and very few staff do so as well. So you have to find other ways --

A. You do.

Q. -- to see if there is evidence and if something is happening; is that correct?

A. Yeah, and that's why I think it's really important that you have different lenses into practice. So my analysis of what has happened in Edinburgh is there are two kind of really key things that happened.

One was a very closed culture and, you know, I've worked in improvement work in different places for a long time, and if you have a closed culture, that's a red flag. So if you have people who don't want you in their services, who are resistant to you being in their services, that's a worry, because why are they being resistant to you being in their services? Surely if their practice is brilliant, they want to showcase that. So if you don't have senior leaders who are asking questions and know the questions to ask and are

relentless in asking those questions, then that's a red flag. So I think there was a definite culture of being closed and a lack of professional curiosity and doggedness in asking the questions.

And there was also a complacency. One of the things that happens -- and it's not just in Edinburgh -- regularly in organisations where things go wrong is they start to reinforce their own narrative. So -- and you can see that in places where they have a failed inspection or where something happens. So people will start to just see the good bits and start to say, 'Well, that's really good because ...', and if you don't have external eyes into that, you don't have a number of different pieces of information that give you that bigger picture, then you can get to a place where you are closed and you reinforce the narrative of 'Everything's great here' and you don't have that professional curiosity and that criticalness.

Q. I am conscious of the time. I just want to ask one question before we finish for the break.

You say there are various mechanisms to get feedback and views from young people who are currently in care, and no doubt you do explore, to the extent you can, whether they feel safe and whether they feel there's anything that they're uncomfortable with or any

concerns. But I think as the SCR showed, they might tell you some things because they're confident of the system, but some matters, such as the ones I've mentioned about feeling safe, they may not give you a straight answer, and you have to have other ways to see.

A. You do.

Q. Not because they're trying to mislead, but they just don't feel confident, even with a trusted person, to tell them, for example, about sexual abuse or some person in the care setting doing something that they don't like. So feedback is all very well, but it doesn't tell the whole story.

A. No, and that's where really good quality practice is about being trauma informed, it's about understanding that all behaviour is communication, and it's about understanding that child and young person.

So, typically, if you see a child and young person who has significant behaviour changes, then that -- you start to ask questions about: why is that? What's going on with that young person if their behaviour changes? You know, if they suddenly become withdrawn, if they suddenly become angry, if they suddenly start going missing. That's why things like if a child goes missing, we do a debrief with them. We give them an

opportunity to talk to people. We look at where they've been, who they've been associating with. It's why the peer network is really important, because some young people will tell another young person what's going on when they wouldn't tell one of us.

Sometimes young people don't experience their victimhood as being a victim, and that's typical in CSE contextual safeguarding, where a young person's been exploited, you know, and I've worked with lots of young people over the years who believe that the person that's exploiting them and buying them things is their boyfriend, you know. So it's making sure that staff are trained to see if a child is coming back with a new mobile phone, with handbags, with goods, to ask questions about that, to get alongside that young person, and it is about understanding who young people have got relationships with and who are the important people in their lives.

And for some young people, that will be us, and for other young people it isn't, which is why working with families is really important, because young people, even if they don't live with their birth family, will still have a relationship with their birth family, and they might be the most significant person in their life. So it's helping families understand where there might be

signs and indicators that there's something going wrong.

And it is -- it's being professionally curious. It's not being complacent. It's constantly asking ourselves: what's it like to be that young person? What's the lived experience of that child like in that place today and how do I know, and what can I do to make it better? And we have to just keep doing that.

MR PEOPLES: Okay.

LADY SMITH: Mr Peoples, is that a good point to break?

MR PEOPLES: Yes.

LADY SMITH: Amanda, I promised you a break about five minutes ago. We will take it now, if that's all right with you.

A. Yeah. Thank you.

LADY SMITH: Thank you.

(11.32 am)

(A short break)

(11.49 am)

LADY SMITH: Are you ready for us to carry on, Amanda?

A. Yeah.

LADY SMITH: Thank you.

Mr Peoples.

MR PEOPLES: Amanda, we've been going through the various bodies that have been either changed in terms of the structure or have been created, I think, since

November 2021.

We had talked about the Corporate Parenting Team. I just wanted to finish off on that one by just -- you've told us about the hub and the Champions Board and how that operates, but the team itself, which is headed by Emily Dempsey, do they produce regular reports and, if so, to whom and what -- they don't have decision-making functions, I take it?

A. No. So they -- there's a corporate parenting plan, which is co-created with the young people. So -- and the Champs Board are really important in that, but so are other young people who are in our care, and that's got a whole range of different elements in it. That -- progress on that and on our promise plan are both reported to the Corporate Parenting Board, which is a kind of hybrid of the two committee systems that we heard about before. So there are elected members on the Corporate Parenting Board, but there are also professionals on that board and young people on that board, and that's the board that oversees those plans, and then that board then reports into the Chief Officers' Group that I mentioned before, but also then does report into committee as well.

Q. Okay.

Just moving, again, to another group that's

mentioned in your statement -- I think it's at paragraph 154 -- a new group that was created.

We've had a lot of discussion about quality assurance arrangements and various teams and groups that have some responsibility for that, but there is this group called the Multi-Agency Quality Assurance group, MAQA, and I just wondered, was it different from the Quality Assurance Team or the Internal Audit Team and, if so, quite where does it sit in the whole scheme of things?

A. Yeah. So the MAQA, as it's referred to, isn't just council, so it's cross-agency, so it has representatives from health and police on there as well, and it oversees the reports. It's chaired by Rose as Chief Social Work Officer, and it challenges and oversees the reports and quality assurance reports that come up.

So, for example, Heather recently did a review of the evidence base for our improvement. So she -- what we asked her to do --

Q. Heather Smith?

A. Yeah. So what we asked Heather to do was look at the improvement plan, and do a review of: was she content that the improvement that we said was in place was in place and that the evidence was there? And then she did a report to MAQA, MAQA asked her questions, challenged

her, asked her for more in depth in certain areas, et cetera, and then that report then goes forward to whichever of the committees it needs to go on to.

Q. And were they satisfied that there had been implementation of the matters she had to look at?

A. Yeah, and Heather herself noticed that there were really significant changes. So Heather had obviously been involved -- had worked closely with Pauline, but then had subsequently done some work on looking at the Gordon Collins review and the lack of implementation in Gordon Collins, which has all come together in the combined implementation and improvement plan that we've got, and so Heather was asked to look at that, look at the evidence base and then report back, and reported back that she'd seen significant change in culture and in practice.

Q. Yes, because I think Heather Smith's role was subsequent to the significant case review of Gordon Collins' case. I'll maybe come back at the end to the Gordon Collins review, but one thing we need to note, I think, is that what was called the Gordon Collins action plan or improvement plan that followed the review was not the work of the review team; it was the work of, I think, Heather Smith, at the end of the day, who was largely responsible for putting the plan in place.

A. She was.
Q. And she also, according to Pauline McKinnon's evidence, was the person who identified something like eight cases that appear to have not been dealt with involving incidents or complaints and had raised that, and I think Pauline McKinnon subsequently said two years on, or actually more than two years on, when she came to look at it, some of these cases hadn't been dealt with as they should have been. I think that's the gist of the evidence.
A. Yes.
Q. You mention another group which I'll just ask you about at this stage before going back to the statement.

There's another group that was established, I think, around August 2022. This is paragraph 50. I just wondered what it did. It's the Improvement Board which was established then, and it seems to meet monthly, I think, paragraph 51.

Can you just tell me where, again, it fits into this scheme of things and what does it do?
A. Yeah. So typically when you're in a change and improvement process, like Edinburgh was in at that point and is still in, you would have a board that has representatives from the key bits of the organisation that's improving, but then you'd also have critical

friends on that board. So it's a model that is really common in organisations where they've failed an inspection, for example. So we mirrored that here.

So I chaired it, but I also asked my colleague, who was a new corporate director, Deborah Smart, who had come from another authority to be the corporate director -- the Executive Director of Corporate Services to co-chair. I asked the Care Inspectorate to be part of that board, and they were. Who Cares? came along to that board as well, again to have external eyes into practice. And I also invited Internal Audit and a monitoring officer to be part of that board. That board has now morphed into a monthly performance meeting where we look at similar information, but it's become more business as usual.

The away day that's happening today is kicking off an end-to-end review of the improvement plan, 'cause improvement plans are live documents, obviously, and you get to a point in time where your plan is old and you need to look at a new one. So we've now moved into another process where we are reviewing from the front door into services to the end of services, what's in place, so there's a self-assessment process that goes with that, and then that will double check that all the areas that we've said we've done remain consolidated.

Because one of the problems in Edinburgh has been that you get a tick to say that's been done, and then nobody goes back a year later to see if we're still doing it. So there's a check and then a new improvement plan will come into place, which will go to committee in June.

Q. Because you can see how people will be forgiven for thinking, when you've mentioned the away day and a refresh of a plan, that there's just another plan and it's more of the same, but will we ever get to the end of the process? Now --

A. Well, you don't, and I think that's really important. I think every children's services organisation should always have an improvement plan, even authorities that are outstanding, that are brilliant. You know, if you look at the history of authorities down south that have failed inspection, they have often been authorities that have been good and have just taken their eye off the ball.

So, you know, what's happening today is a celebration of the improvements that have happened -- and, you know, there are lots of improvements that have happened; lots of people have worked really hard to deliver some really good practice -- but then to look at: so how do we get even better and what do we need to do to be even better?

So we'll always have an improvement plan; it'll never be finished.

Q. Because you tell us in your statement, I think, about the away day, but also that there's some intention to submit -- is it a revised plan in July of this year?

A. Yeah. It's the June committee.

Q. Or June, to the council.

A. Yeah.

Q. Which to some extent will be the current improvement plan but with modification?

A. Yeah. So I'll give you an example.

So one of the areas that isn't in the current improvement plan in a lot of detail is around educational attainment of children who are in our care. So -- and the attainment of our children is not good enough, so we need to really focus on that and we need a really robust plan that's monitored by committee to make sure that that -- you know, education is life-changing for our children, and to make sure that they're absolutely getting the best education they can be. So we need to have a much more detailed focus on that. That's not in the current plan.

So, you know, as we go through audit, as we go through continued learning about what's going on for children, that plan will change and will focus on

different things.

Q. Because I think the current plan to some extent is a development of both the action plan following the Gordon Collins review, the recommendations of the Pauline McKinnon report and maybe, to some extent, other things, and picking up what were historically systemic issues or themes that were picked up in these reviews and reports.

A. Yeah.

Q. Therefore, a large number of the recommendations were embodied in this current plan, a single plan for -- originally, to some extent, it was for ESS, but then became a plan for the service, children's services as a whole, because you wanted a root-and-branch, I suppose, review and improvement.

A. Yeah, and I didn't want multiple plans because then gaps -- things fall down the gaps of multiple plans. But also, you know, children's services is a system. So if you take a care plan, for an example, you know, a care plan is a really important document. It's really key that children have good care plans, they're involved in their care plan, it understands their needs, it meets their needs. A care plan is the responsibility of a field work social worker to write that care plan with all the other professionals that are involved. So if

we'd just had a plan that was looking at residential improvement, it would have looked at the day-to-day care of those children, but it wouldn't have looked at wider care planning.

So it needs to be an integrated plan 'cause it's an integrated system, and parts of that are multi-agency, you know, because parts of it is around -- so one of the things that's in our -- going to be in our new plan going forward is around dental assessments and dental support to our children in care, because, again, access to dentistry is not as good for children in our care as it should be, so we need to really focus on that.

So some of it's within our gift and some of it's wider and involves our partners as well.

Q. Now, maybe I should mention another group just in case. I think at paragraph 31, another new group was established in January 2022, the Governance Oversight Group. Is that still in existence?

A. Yeah.

Q. Again, can you maybe just help us a little with what it does and what's its composition, and how does it --

A. So that was originally just in relation to Howdenhall, so that group then morphed into the development group -- so Howdenhall closed and, prior to the closure of Howdenhall, we did a full-scale service review of: did

we need Howdenhall anymore in its secure form? If we didn't need Howdenhall, what else could we do with it and what else did we need to do with it? And we have a managing change process that we work to in the council, and that's what we did. So that group became that change group, and the kind of oversight and quality assurance of that group for the wider service is now within the MAQA group that we talked about before.

Q. This group itself, is it made up of officials or councillors or multi-agency or --

A. That was officers. So it wasn't --

Q. Officers?

A. Yeah, it wasn't elected members.

Q. This is an officers group?

A. Yeah.

Q. And it still exists, and to some --

A. No, the actions of that group go into -- are now in the MAQA group.

Q. Of the Governance Oversight Group?

A. Yeah.

Q. So it doesn't exist anymore?

A. No, not anymore. The activity's gone into MAQA.

Q. Because it was originally conceived to kind of take forward changes to Howdenhall --

A. Yeah.

Q. -- and ESS.
A. Yeah.
Q. Because Pauline McKinnon's report didn't recommend closure at that phase.
A. Yeah.
Q. And there was an attempt, I think, to see if the issues could be addressed, and we'll come to the closure.
A. Yeah.
Q. So that group was to some extent set up for that particular purpose?
A. It was looking specifically at Howdenhall, and then it was, as I say, superseded by the group that looked at: okay, so what's the future of Howdenhall?
Q. But am I right in thinking that -- well, you have a current improvement plan for children's services.
A. Yeah.
Q. That's the one that's the subject of discussion at the away day and may well be revised --
A. Yeah.
Q. -- and a revised plan submitted in June of this year.
A. Yeah.
Q. Am I right in thinking that there is a body or a group responsible for seeing that that is properly implemented from time to time, depending on what the plan itself says but is there an implementation group still in

existence, and if so ...?
A. No, the performance group looks at the performance of the whole service, so that's a monthly meeting.
Q. Yes.
A. And it reports to committee.
Q. So there's no implementation group for the actual plan itself?
A. No, because it's business as usual. We are in the business of improving our services. That's what we come to work to do.
Q. But there was a time after the ESS report where the council did set up such a group, was there?
A. There was, but I think that was in a -- that was at a point where the culture was very different and where the practice was very different, you know, where improvement was seen as something that was unique and a specific activity, and we are moving away from that into a place where we're a learning organisation. We want to look at -- we want to be an organisation that continuously improves, that's continuously curious. So that's why there isn't an end point. That's why there isn't an architecture that says this is just about improvement. This is about performance, which is why it goes to a performance meeting.
Q. So what had been this sort of improvement group and

became a performance group that now meets monthly is the performance group that is looking overall at the service and how it's improving and what needs to happen?

A. Yeah.

Q. And it's reporting to council committees?

A. Yeah.

Q. And also does it contact the Multi-Agency Quality Assurance group as well?

A. Multi-Agency Quality Assurance group feeds in to the performance group, and also feeds into the other committee, so Child Protection Committee. There are a range of other multi-agency partnerships that we would feed into as well.

Q. So insofar as there is a plan, though, the group that has direct responsibility for the plan from time to time and to discuss it as the performance group, to see if it's progressing as it should do, if it's stalling or if there's delay in progress and, if so, why; is that its function?

A. We would monitor the plan, yeah, and then it would go to elected members. So it goes to -- so it goes regularly to committee. So that's the overview report, and then committee will ask for specific reports on particular aspects of it.

So tomorrow there is a report that's gone to

committee that covers what the constituent elements of a quality assurance system are, because the committee has asked specifically around quality assurance.

Q. Yes, they want to know as much as we do, really --

A. Yes.

Q. -- and just to make sure that this isn't all just smoke and mirrors.

A. Well, and so do I, you know, it's my name that's over the door.

Q. Yes. But you can understand why they and others would be asking this question.

A. And it's the right question to ask, you know. So one of the things that's really important is that lots of people ask questions about these services, and, you know, it's that thing about having a number of lenses into service, but also a number of eyes on service. It's -- and it's really important that you should have that.

When I got my first director's job, a long time ago now, a very seasoned director then said to me, 'If a committee feels like a coffee morning, then it's a coffee morning', because it should feel quite uncomfortable when you go into committee. You should -- you know, you should have a kind of frisson of nerves in going to committee that you're going to be asked some

difficult questions, and that's right, you know, 'cause we're here to make sure that we're doing the right thing for children and young people.

And I will see things, because I don't directly line manage practice on a day-to-day basis, that other people won't see, but so will elected members and so will other professionals, and that's really important.

Q. Now, you have the professional groups and the multi-agency professional groups. You've also got council committees, and one is meeting -- is it tomorrow?

A. Yeah.

Q. And hard questions may be asked.

I just wanted to ask you that. I mean, clearly governance does involve active participation by the committees themselves and an interest and a curiosity that you have to have.

A. Yeah.

Q. Are you getting that at the moment from these committees? Do you feel that they are doing the job of making you feel at least nervous when you go in, keeping you on your toes, asking the hard questions? Are you sensing that?

A. Yeah, and, you know, children's services is a complex area, and that's why we do a lot of briefings. That's

why we do a lot of support to members to go and be involved in our services.

I'm really lucky with the committee that I've got, because some of the elected members that are on the committee have got a background in these services as well. So, you know, I've got teachers and social workers that are on the committee, which is really helpful because, you know, they have a professional lens into practice. I've also got other members of the committee that have been part of the hearing system. So they have a different lens into practice.

But it's also really useful to have people on that committee who are really interested in this world but don't have a background in it, 'cause they'll ask different questions, and that's really key. So --

Q. I mean, I think the council itself hasn't been without its problems in terms of the councillors and certain -- I think there's currently even questions being asked about certain councillors and activities they were involved in and whether they were sufficiently investigated, and of course, if they weren't, the question would arise: well, it's all very well trying to do things at an officer level, but if the committee and the council itself is doing the very things that you're trying to address, you're not going to get as far as you

should do.

You know about these things.

A. Yeah.

Q. There are ongoing allegations, and I think they've been the subject of recent publicity --

A. Yeah.

Q. -- including by members of the council themselves who feel strongly. Is that right?

A. Yeah. And again, that's why -- I mean, you've described a lot of committees and a lot of different boards, and, you know, if you're looking from the outside in, you could see that as kind of quite a complicated picture. But it's also important that there are a number of different places that are looking at practice and through -- and, you know, in different ways and through different lenses.

Q. Because it's often been said that governing bodies -- I'm not just thinking of local authorities, but managers of establishments -- although they had key roles, often just either were led by influential persons in charge of establishments, like headmasters in List D schools, and they concerned themselves with some matters that they probably saw as important, but not necessarily things like welfare or children's safety, questions of complaints and patterns of behaviour and the like.

But do you feel that, at council level, these matters do get discussed, do get considered and questions are asked?

A. Yeah, I do. I think our members are really concerned that we're good corporate parents and they're really concerned that we give the best service that we can do. If you look at -- so a really tangible example of that is if you look at the budget process which we are going through at the moment, and, you know, all local authorities at this point of the year are going through a budget process, and all local authorities at this point of the year are making really difficult decisions about where they can make savings, because we don't have enough money to continue to deliver all the services that we want to deliver.

I feel really supported by our members that even if I put savings forward, very often they mitigate those savings and they find those savings elsewhere, and that has been my experience here, and it is likely to be my experience for this year as well. You know, members have been really keen to make sure that I've got the resources that I need to continue delivering the right service.

Q. Because I think historically, again, as the significant case review pointed out, that there was a period of time

in the history of the council where they weren't filling vacancies in children's services and key posts, just to save money.

A. Yeah, and that's never been an issue since I've been here. And, you know, if we use the example of Mosaic, that's a multi-million pound project that elected members have put the money in, you know, and seen it as really important, seen it as an important change project.

LADY SMITH: Amanda, as I listened to you describing the many committees there are and have been -- of which you have an enormous grasp, I see that -- it sounds like an awful lot.

Would I be right in thinking that you have an organigram of these committees that gets regularly updated?

A. Yeah, and there's the --

LADY SMITH: Can we see that, please?

A. Yeah, you can, and there's -- the democratic part of it, so the elected members part of it as well, is regularly reviewed in the reports to council. So there's an annual council every year where nominations to each of those committees are made. So all of those reports are in the public domain, so we can highlight those to you as well.

LADY SMITH: That would be very helpful. Thank you.
MR PEOPLES: Because I suppose the danger is that if we've got a lot of committees, they each wonder what the other is doing and whether there's overlap or they're fulfilling a particular role, or they have a clear idea of what their own responsibilities are.

I take it that they do get told what exactly their direct functions and responsibilities are, whether they've got any decision-making powers, whether they have any other committees or bodies to which they should be accessing or reporting or taking information from? Is that all understood? Because it's quite complex, as the Chair says.

A. It is complex, and there's a scheme of delegation which spells all of that out. But there's always debate, you know. So tomorrow there will be debate around what's operational, which is supposed to be within my gift, and what's strategic, which is supposed to be set by elected members, and we'll always have a debate over where that line sits, and that's healthy. That's a healthy debate.

You know, I am really pleased that our elected members are involved in operational practice, because I want them to be asking questions about operational practice, and I want them to understand the detail of it.

Q. Well, forgive me, I don't actually see a problem with people who have got some oversight in governance being concerned with operational matters.
A. Absolutely.
Q. They don't run them, but they have to be asking the question, surely?
A. Absolutely.
Q. That's their job, isn't it?
A. Absolutely, yeah, and I'm really pleased that our members are interested and do that.
Q. Now, there is, within children's services currently, is there, a complaint service?
A. There is.
Q. And does it sit within children's services?
A. It sits in Rose's part of the world.
Q. The Chief Social Work Officer?
A. Yeah.
Q. So it's not within the service director's area?
A. No. We've got an organisational review going on at the moment, which is finalising the structure, but complaints is moving over to Rose's area, and there's going to be an expansion in that team as well.
Q. Where did it sit before it was moving?
A. It previously sat within the service, so in the operational part of the world.

Q. So the complaints service was not independent of the service that might be complained about?
A. No, it wasn't. And the other thing that isn't in place and is going to be, if it gets through the budget process, is a mirror of a LADO post, so a local authority designated officer post.
Q. Yes, I was going to come to that, so maybe just leave that one for the moment.
A. Okay.
Q. We'll come back to that one, because I think it does relate to complaints, but I'll try and pick that up when we go back to the statement.
A. Yeah.
Q. I just want to understand where the service sat just now, and historically, it didn't sit in a good place, I would have thought.
A. No, and again, it was another area where it was a missed opportunity to kind of pull together lessons learned and to look at themes from complaints.

So we do have a regular report that comes now which covers what complaints have happened, what the themes are, whether they're stage 1 complaints, stage 2 complaints, and then that feeds into learning and development. We do an audit twice a year of complaints.

It's probably the area that I think we still need to

do more work on most out of all of the areas. We haven't got enough capacity in complaints at all. We do need to expand that team and we need to put more resources into that team, and we will do that as part of the review process.

Q. Now, my understanding is, certainly historically, there came a point where, instead of an establishment-level complaint system, the council moved over to saying that if someone made a formal complaint, it would go to an external manager within the Social Work Department and that it would normally be dealt with by an investigation officer appointed by the external manager or someone within the headquarters, and they would prepare a report, they would determine whether the complaint was well-founded or not, they would determine whether there should be disciplinary proceedings brought against members of staff and so forth. That was the historical sort of process, wasn't it?

A. Mm-hmm.

Q. And to replace what had previously perhaps been an establishment-level system that simply took a complaint, the head of the establishment or someone in a senior position would consider it internally and not necessarily refer it on, and would make what they considered to be the appropriate decision, which usually

probably meant the staff member concerned stayed in post.

A. If it's a complaint about a member of staff, and if it's an allegation against a member of staff, then there's a separate investigation team now which sits outwith our services. It sits in legal services and it sits --

LADY SMITH: Amanda, can I just tease this out, because I see that in -- I think it's paragraph 95 -- you refer separately to allegations of abuse against staff and complaints, and I'm getting the impression you now treat those as two different creatures, if I can put it that way. Have I got that right?

A. Yeah. So complaints will cover anything that a person complains about. So, you know, a young person might complain about the food that they get in the house that they're in, and that -- you know, and that's right that they do that and that's investigated, and they're often supported by advocates to put that complaint forward, but that's a different process to a complaint against a member of staff or a complaint about -- an allegation about the quality of the care that they're in and them feeling threatened, there being a child protection concern. There are different processes for that. And if it's an allegation against a member of staff, then that's done by a separate, independent investigation

team.

LADY SMITH: Thank you.

MR PEOPLES: I'm going to come to that. But the complaint service, though, that you've mentioned, there is one currently which sits within legal services?

A. No, that's the investigation team sits within legal services.

Q. Right, so the complaint service sits within children's services?

A. Yeah.

Q. But if it involves, for example, an allegation of abuse by a staff member against a young person, just talk me through where that goes. Let's say there's a disclosure or an allegation, what would you expect to happen? It doesn't matter how it comes about, but let's assume --

A. So the immediate bit is the safety of the child or young person. So there would be an IRD process, which is a referral discussion we talked about before, which would put an immediate safety plan in place.

So if that young person is still living in the context with the person that they've made the allegation against, you'd look at what the safety plan looks like. So it might be that, you know, if it's against a foster carer, that the young person moves; if it's against a residential carer, that the member of staff is

suspended. So you'd have to look at the immediate safety. And you look at whether or not there's a police investigation, you look at whether or not that child is going to be supported through the SCIM model, which is the investigation and interview model, whether or not that's going to happen.

You'd also have a parallel process with HR, who would look at what the allegation is and how that allegation is going to be managed, and the first thing that we would do, where there's any allegation, is we'd go through a suspension checklist. So we'd basically look at: if there's an allegation against a member of staff, do we suspend that member of staff immediately or can we do action short of suspension? So can we move them to another place where everybody's safe in that scenario? And then there's an investigation into that process. So there's an investigating officer, who would be one of the team that sits in in legal services, and a nominated officer who's the person that oversees that investigation.

Q. But what's the investigating officer investigating?

A. Investigating the complaint that's been made by the young person.

Q. Because the allegation, in a sense, is a species of complaint, isn't it, in essence?

A. Yeah, yeah, and it can -- you know, it can be different things. It could be -- you know, it's a whole range of different things that young people will raise.
Q. So there's an internal investigation team that now sits within --
A. Legal services.
Q. -- legal services, who will look at and investigate complaints.
A. Yeah, yeah.
Q. The complaint service itself that sits within children's services then, what are they doing in this scenario? Do they have a role as well?
A. So they're doing that -- they would be involved in that complaint, i.e. they would log it as a complaint, but if it's an allegation, it goes to the allegation route, rather than it being, you know, 'I don't like fish fingers on a Thursday'. That's a different order of complaint.
Q. So if we're talking about the complaints we are interested in, effectively, if it's an internal investigation, it will go to the investigations side and it will be investigated there?
A. Yeah.
Q. And there could, arising out of that investigation, be disciplinary action against a member or members of

staff?

A. Yeah.

Q. Allegations such as conventional abuse, simply straightforward sexual or physical abuse or assault, would go that route?

A. Yes, but --

Q. Allegations of inappropriate restraint, would that go the same route?

A. Yeah.

Q. Abuse of practices, would that go the same route?

A. Yeah.

Q. I mean, just to take a historical example, I don't know, bed-wetting. If bed-wetting had resulted in staff humiliation.

A. That would go that route.

Q. Verbal abuse by staff?

A. Yes.

Q. These would all go that route now?

A. Yes.

Q. Now, tell me this: you mentioned that you have an independent investigation body, and we heard an example -- this was the investigation by Pauline McKinnon -- was a referral to Safecall.

A. Yeah.

Q. And Safecall is this investigation body that will

normally themselves investigate serious complaints?
A. Yeah.
Q. These could be complaints made via a hotline?
A. Yeah.
Q. Or they could be simply complaints like the one Pauline McKinnon had to deal with, which came from a disclosure to a senior official, who then referred it to Safecall?
A. Yeah.
Q. So there could be a variety of ways they could become involved.

The specialty in that case, the McKinnon case, was because of COVID and other factors, it turned out that Safecall enlisted a quality assurance officer within the council itself to carry out the investigation, and it would appear that, in the end, they made a very good choice, as they confirmed. But, normally speaking, they would simply conduct what should be an independent investigation?
A. So Safecall would deal with whistleblowing.
Q. Whistleblowing?
A. Yeah. So -- and anybody can make a whistleblowing complaint. So any member of staff that is concerned about anything can go direct to Safecall. They can do it anonymously. And they can do it completely

anonymously, so Safecall don't have to know who they are, or they can do it anonymously so Safecall know who they are, but nobody else knows who they are.

When a whistleblowing complaint is made, you don't know the detail of that complaint. So if somebody whistleblows against me today, I don't know that that whistleblowing complaint has happened. I don't know the detail of that complaint.

If there is a whistleblower complaint against a chief officer, then that is investigated through Safecall, but Safecall also go to an independent legal firm to do that investigation. So that would be seen outwith that process.

If it's an allegation against a member of staff that -- you know, if a young person came to see me today and said they'd been hit by residential worker B, that would go through an internal investigation process through the investigation team, which sits in legal, with HR oversight as well, and it would have police involvement in that because that's an allegation of assault, so we'd have to have the police involved as well.

Q. So that wouldn't go to Safecall?

A. It goes to the investigation team, which -- 'cause it's not whistleblowing. Whistleblowing is the Safecall

service.

Q. But if it's not through the whistleblowing route, but it's simply a disclosure to a member of staff that there's been a serious physical assault, say, or some form of alleged sexual abuse, who's going to end up investigating that?

A. The police would investigate that.

Q. That would go to the police?

A. Yeah, that would also -- so that initial referral discussion is with the police, so -- if there's an allegation of abuse, whatever that abuse is. So that would include verbal abuse. That would include belittling behaviour. That would go to the police. And then the police would make a decision on -- because the police investigation in those circumstances takes paramountcy because, you know, they would then investigate, and then we would take any workplace investigation forward.

Q. Yes, I follow that, but it may be that they come back and say, well, some forms of abuse may not be necessarily a clear criminal offence, and if they decided to close their particular investigation after referral, then it would be dealt with internally?

A. Yeah.

Q. It wouldn't be dealt with by Safecall?

A. No, it would be dealt with through the investigation team.
Q. So are Safecall essentially mainly called on when it's whistleblowing?
A. Yeah, it's a whistleblowing service.
Q. And it can deal with anonymous complaints as you've described.
A. Yeah.
Q. And they do still investigate these --
A. Yeah, they do. They do. And we can also put management referrals through to whistleblowing as well. So if a member of staff came to see me and said, 'I think there is an issue in team X and I'm really concerned and here is what I'm concerned about', I would put that through to Safecall and they would do that investigation.
Q. Yeah, because if the allegations might involve colleagues or people in the same team, even if you have a more independent investigations team within the council, they could easily have had some kind of dealings with the persons involved. So it would make sense to effectively contract that out to Safecall.
A. Yeah. And that's what you would do. If there were those kind of concerns that it was systemic, you'd go through whistleblowing.

Q. Okay.

Now, we're talking in the context of improvements and, of course, we've covered quite a lot of ground this morning, so I'm not necessarily going to take you through some of the things in the statement, but you do tell us, I think, about a range of measures. If we look, for example, at paragraph 14, there's a range of things that have been done since you came on board, and we can read those for ourselves.

I think you've touched on some of them this morning, and you've referred to the fact that you don't run a secure service anymore, but you do have residential houses, small units, six people, or about?

A. Five.

Q. Five?

A. Yeah.

Q. And that they are inspected periodically by the Care Inspectorate, and I think what you're telling us is that at least the recent reports have scored them well.

A. Yeah, so all of our houses are 'good' or above now, which is a change for a number of them and a significant improvement for them.

Q. You say that -- and I'll just pick this up in passing, because we're not looking at this type of accommodation in this particular case study, but what you do say is

that you've sought to introduce a robust matching process which tries to get a better fit or match between the young person and a particular house, because I think historically we've seen -- and this is not news to you -- that it wasn't always a system that matched according to need; it was according to availability, often, that people ended up in places that ultimately might have been totally unsuitable?

A. Yeah.

Q. Just in passing, what's a Promise Award and who gives it?

A. So this was developed by -- I think it was one of the Lanarkshire's, who developed a system to do a self-assessment and then an accreditation around The Promise.

LADY SMITH: So you're talking about either South Lanarkshire or North Lanarkshire local authorities?

A. Yeah. Yeah. I think it was South Lanarkshire, but I can double check.

And it was basically looking at the elements of The Promise and looking at what does good residential care look like, and then an award that links to that.

So each of our houses have gone through that process and have met the requirements for The Promise Award.

MR PEOPLES: Who decides if you get the award?
A. So it's a self-assessment process, and then there's a validation process of that as well.
Q. But who validates it?
A. It's not validated externally.
Q. No.
A. But it is -- it's not our system.
Q. No, okay. Right.

If we go specifically to Edinburgh Secure Services. Now, I mean, we can to some extent take this quite short in terms of the service itself because, as you tell us at paragraph 16, it no longer exists as a service. I think that it closed its doors, I think, probably at the end of July 2023. The decision may have been taken before then. We can read the history of it from other documents, and I don't plan to do that today, but I just want to look at that bit.

You tell us that that service no longer exists and that the council no longer has any secure provision, and I think we know from other evidence that any secure provision currently in Scotland is all provided by charitable bodies; I think Kibble, Rossie.

A. Aberlour, Good Shepherd.
Q. Good Shepherd.
A. Yeah.

Q. Although, obviously, there's less provision because of the closure of ESS, although I think ESS was a relatively small provision latterly.
A. It was -- it had eight bedrooms and -- but it wasn't using the eight bedrooms. When I came, there were two young people in closed conditions, and we didn't allow any other additional children to be admitted to it until the improvements had happened, and then we capped at three, and then, just before it closed, we capped at four.
Q. Yes. I think if an Edinburgh child or young person requires secure care, for whatever reason -- just leave it at that at the moment, because you've got some observations on that, but if they do -- what would happen now is that you would have to go to one of the providers of such accommodation?
A. Yeah.
Q. Is it always a Scottish provider?
A. Yeah.
Q. Yes. Because historically, and perhaps not that long ago, some of the secure provision was taking people from south of the border, and it may be that the same was happening the other way?
A. It does, and there has historically been a competition for those beds. But I think practice has changed. You

know, we'll come on to it later, but the system has failed if we need to put a child into secure, and we don't have any children that are in welfare secure at the moment. We have children that are in because they're in conflict with the law and it's sheriff directed, but we don't have any children in secure for their welfare needs at the moment.

Q. Yes, because you tell us that -- I mean, just while Howdenhall or ESS continue to exist -- and I think you call it Howdenhall because, effectively, St Katharine's Secure Unit --

A. Had gone.

Q. -- had closed in 2016 -- while it was still open, there were some changes, one of which involved an external manager, Scott Dunbar, being replaced by Steve Harte, who we've talked about earlier today, and there were some other changes, and I'm not going to go through the detail of that today.

You obviously refer at paragraph 25 to Pauline McKinnon's whistleblowing report, which was highly critical of ESS and the council, and I think you've said that that was fully accepted by the council and, indeed, an attempt was made to incorporate her recommendations -- some 44 in all -- into an improvement plan.

A. Yeah.
Q. You tell us about the improvement plan, and I think, taking this short, what happened initially was that it was left to certain individuals to come up with an improvement plan, to draft one, and it seemed to take quite a long time, and then, when they finally produced it, you weren't happy with the plan as put together. Indeed, you tell us, I think at paragraph 29, it was incredibly detailed and overcomplicated with no real ownership, and the upshot was that the plan had to be revised before presentation to elected members around, I think, 22 March, or thereabouts, of 2022.

Is that the kind of way things unfolded?

A. Yeah. I mean, I think what had happened is people were trying to learn the lessons of the past, so had created a really complicated plan, which had got levels of assurance within it as to what the evidence was required and -- but it was too complicated to make any sense, and it was really hard to make sense of: what were the things that needed to happen immediately, and then what were the things that would happen short term, medium term and longer term? So that's why we did the revision of the plan.

And that was at the same time as we got a new management team in. So Steve became the head of

service, but Mark Crawford, who was one of our social workers, but not in -- hadn't worked in secure or residential services, came over to be the manager of the secure service, and he then led that part of the improvement plan.

Q. So this is still when it's operational.

A. Yeah.

Q. These things are happening. The improvement plan, to an extent, had to be redrawn and then presented to the council, so that took a bit of time, but a plan was presented, I think you tell us, in around March, is it, 2022?

A. Yeah.

Q. This was, I think, maybe known originally as a sort of consolidated action plan, and the reason it was called that, I think, was that it was an attempt to amalgamate recommendations from the Gordon Collins review that hadn't been actioned or sufficiently actioned, along with the Pauline McKinnon recommendations, and that was what you referred to as the consolidated action plan?

A. Yeah.

Q. That's not the plan now, because that was a plan for ESS, whereas what you then asked for and thought was necessary was a single plan for the whole of the children's services. You told us why; you felt that the

whole service needed improving, not just one particular service?

A. That was the plan for ESS and residential.

Q. Yes.

A. Because what was clear from that plan was that some of the issues that had existed in secure services also existed in residential, so that plan was across the piece. So the actions in that plan are now part of the bigger improvement plan. But all of those actions have transitioned into the bigger improvement plan.

Q. That is a recognition that these issues weren't establishment-specific; they were systemic issues affecting the whole of the service?

A. Yes.

Q. While ESS remained open, I think you told us that the Governance Oversight Group that we talked about earlier was established and it had various functions, one being to make quarterly visits to Howdenhall, to prepare quarterly reports of progress against the plan, the consolidated action plan, and to make quarterly or to -- is it to receive or to make a quarterly report to the corporate parenting officer?

A. It was to make reports to corporate parenting.

Q. To make, and there was also establishment of a Performance and Improvement Team to do with that plan,

and did that happen while ESS remained open?

A. Yeah. So there was lots of work on improving ESS as it then existed, but pretty quickly it became clear that, actually, we didn't really need ESS anymore, and we were an anomaly. We were the only local authority that had a secure unit.

So we then transitioned that into a project plan and a project team that was looking at: so what could we do instead of ESS? And that's what led to the closure of ESS and the establishment of the Edge of Care team, which has been about preventing children and young people coming into care, which has been really successful and really important. So it is about working with young people who are on the edge of coming into care, really intensive focus on working with them and their families to prevent them coming in.

Q. That's preventative work to try and prevent families being broken up or coming into care settings?

A. Yeah.

Q. I suppose the fewer people in care settings, to some extent that will reduce the incidence of potential abuse or ill-treatment and so forth, because you've got a smaller population. It's not a guarantee, but at least the numbers would be less if there were still problems, because you're basically, I think, trying to

work towards young people in need of some form of support remaining in the community.

A. Absolutely. Most children should be with their families, you know, and most --

Q. Or a substitute family.

A. Well -- and most children should be with their birth family. Most children that have been in our care maintain a relationship with their birth family and end up going back to be part of their birth family when they leave our care. So it's really important that we maintain families wherever we possibly can. So the Edge of Care service is about really intensive support to families, and have prevented a significant number of children coming into our care.

What it also does is means that we don't have children coming into care in emergencies. So you mentioned before about having the wrong mix in houses. 75 per cent of children coming into care came into care in an emergency. So they were often children we didn't know or we didn't know very well because we hadn't got that preventative work right.

That's significantly less now. So in the most recent audit we've done, only 8 per cent of children didn't have that care planning that was needed before them coming into care. So that means that children that

come into houses are children that we know. That means that we match them better. It means that they're less likely to -- their placements are less likely to break down. So it's making the whole system safer by better social work practice.

Because social work practice is about only being involved with families that really need social work support, being really clear about why you're involved in their family and how you can help them, and then getting out of their lives when they're not -- when they don't need social work support anymore.

Q. You tell us under your section on admissions to care that you took the decision to restrict admissions to the secure unit until improvement works, as you put it, were done, and you put a freeze on accepting new admissions until it was agreed between yourself and the Chief Social Work Officer that there had been sufficient improvement to allow, perhaps, some easing of the restrictions.

A. Yeah.

Q. Although I think you ultimately still capped occupancy to, for most of the time, 50 per cent of the capacity.

A. Yeah.

Q. Just briefly, if I could ask you this: I mean, what convinced you that improvement was sufficiently embedded

to enable you to ease the restrictions? What was it that was happening at Howdenhall that hadn't previously happened that satisfied you that your initial freeze could at least be thawed a bit?

A. So we'd got a whole new management team. We'd got lots of work going on on the physical environment in the building. We'd got lots of work going on around support to the staff, training to the staff, particularly training around CALM. We'd got new sets of policies and procedures. So lots of work that was going on around changing it.

But I think what was really important as well was physically seeing Howdenhall, being in Howdenhall, experiencing Howdenhall. So I went to Howdenhall when it was initially apparent that concerns were there, and it was a stark and unpleasant place to be. It's a very stark building. It didn't feel warm. It didn't feel nurturing. There was a quiet space, which was a small room which had got -- you know the chairs that you have at like a bus shelter that are kind of bolted to the floor? It had got two of those in the middle, and that was where children were supposed to go if they needed quiet, reflective time. Nobody was going to go and sit on a bus shelter chair that was bolted to the floor. It just wasn't going to happen.

Q. I wonder if it was used for more than quiet, reflective time, as a place of isolation or segregation?

A. Absolutely.

So what happened was a lot of work on the physical environment and a lot of work with the children that were in the house -- so there were two children in the house at that point in time -- around how that should change.

So that room, for example, became the blether base, which is what the young people wanted it to be, and they wanted it to be a space where they could go and have a chat with somebody that they trusted. The chairs went. It got completely redesigned as a sensory space.

So there was a lot of physical changes to the building. There was a lot of changes in practice. So people were talking about care. People were talking about love. There was a lot of work around making sure that children and young people understood their rights. Who Cares? were in there very regularly. There were fortnightly meetings with Who Cares? to make sure that children and young people were supported.

One of our participation officers at the time had previously been a resident in Howdenhall, and she went into Howdenhall to look at what changes had happened and how different it was from when her time was there.

So, again, it was lots of different eyes onto looking at the provision, but it was also being much more critical about: why were we using secure in the first place?

Q. Well, I'm going to come to that now, because you have a section at 54 to 59 that I'm going to come back to, the file review, because that I think is an ongoing issue, and I'll come back to that.

If I can just continue with children's secure care and explore -- I think you give your reasons for -- I don't think you're a fan of secure care --

A. I'm not.

Q. -- if I can put that briefly at this stage. But you say, in fact, that when you started in November 2021, Edinburgh had 12 children in secure care for welfare purposes, either in Howdenhall or in some other secure placement, and today you tell us -- is this the position? -- that there are no children in secure care -- which would be outwith Edinburgh now -- for welfare purposes.

A. Mm-hmm.

Q. Now, just a couple of things.

The children that are in secure care, the Edinburgh children, are there because they've been sentenced to a form of sentence that requires them to be held in some

secure accommodation?

A. So there is an alternative to adult custody. So it's sheriff-directed, yeah, and there are seven at the moment.

Q. And we know now that they can't go to a young offenders from last September.

A. Yeah.

Q. So if they require, through the judicial process, some form of secure care, they have to go to one of the recognised units -- provided they've got capacity, of course -- and what you call children who are in secure care for welfare purposes, can we take it that that's essentially the sort of children that historically were there for care and protection reasons --

A. Yeah.

Q. -- whether because they were in moral danger, whether they were seen as children who were missing school for whatever reason, they might be seen as persistent absconders from open units that they had been sent to, residential units, or List D schools or the like; that's the sort of --

A. Yeah.

Q. -- type of -- that's a welfare case?

A. Yeah.

Q. And you don't have Edinburgh children or young persons

in that category at present?
A. Yeah.
Q. But before I go on and ask you more about your own views on the whole matter, do I take it that it's not, however, City of Edinburgh Council's official policy not to use secure care for welfare reasons or purposes?
A. It's not our policy, but it would be extremely unusual for us to do that.
Q. Yes.
A. And it needs to be a decision by the Chief Social Work Officer.
LADY SMITH: Could you give me an example of when it might happen?
A. Erm, it is very, very rare that Rose or I would agree to that. If you had a child who had extremely complex needs, and particularly had some really challenging mental health issues, you would hope that the mental health system would pick them up and would be available. There are times when there is not mental health provision available, and if it's then a risk of a child who's likely to be -- significantly injure themselves, then at that point I could see why you would consider secure. It'd still be something that I'd be really uncomfortable making that decision, and I would want to be working with my health colleagues around: what else

can we do for that child that means that that's not -- because secure care is not set up for supporting children who are in mental health crisis. So I think it would be really unusual.

It was -- secure care was often used for children and young people who were being exploited, and I think that was -- I can understand why you would think taking a child out of a community and putting them somewhere a long way from that community could break the cycle. But I think that's a kind of naive understanding of how abuse cycles work and how exploitation works, and it's revictimising a victim. You know, what you need to do is look at how do you disrupt and find and bring the perpetrators to justice, rather than removing a child from a community that is ultimately their community and they will go back to anyway.

LADY SMITH: Yes. Thank you.

MR PEOPLES: So the sort of cases that I've just mentioned; truant or exploitation or absconding and so forth, would not be the sort of cases that you would consider using secure care for?

A. No.

Q. But you're not ruling it out in exceptional circumstances, although I got the impression from your last answer that the reason you might sanction it or

approve it is not because you thought it was the best placement, particularly for someone with significant mental health needs, but because there was a lack of alternative facilities that are better suited to dealing with those needs, even in some sort of secure conditions.

A. Yeah.

Q. Is that the reality? That it's just because the facilities that should exist, don't exist in sufficient numbers to deal with those cases?

A. Yes.

Q. It's a bit like the old system of List D. People were stuck in there with complex problems, sometimes mental health issues, because there weren't the facilities in the 1970s, I suppose, and I think children's hearings in Scotland certainly were crying out sometimes to say, 'Well, give us other choices', but that didn't happen.

A. And we have to look at different provision for children. So at the moment, we are -- we're in the process of buying a house that is going to become a solo placement for a young person, and it's a young person who's got really, really complex needs and who can't manage in a bigger children's house, can't live with four other young people, and who needs a placement all of their own and will need a placement into adulthood. So we're

working with our colleagues in adult services, we're working with our colleagues in health, we're buying a house, we're turning it into a placement that will just be for that young person, and it will be where they live for the entirety of their care journey. We need to do things like that more.

Putting a child in secure isn't a permanent option anyway. You know, children go into secure for short periods of time and then come back out, and what was happening with our young people is they were going into secure, coming back out of closed conditions, then going back in, coming back out, going back in. That just is not effective care planning, and it's not appropriate for a child to be in and out of secure. They need a permanent care plan and they need a permanent place to live that's going to meet their needs, and secure can't be that.

Q. I think you say at paragraph 62 -- and I think it's echoing what you've just said -- that:

'Children were ... put in secure care [for example] for their own protection to stop them being exploited which is an outmoded practice ...'

I think you feel, at paragraph 68, that your view is if you get to the point where you have to put a child in secure care, I think essentially for welfare reasons,

the system has failed, and that it should only be happening in exceptionally rare circumstances.

Is that your own view?

A. Absolutely. You know, locking a child up can't ever be the best answer for that child. You know, if we are working in a way that is understanding trauma, if we're working in a way that's offering early help, early support, early intervention to children and young people and their families, then if we get to a point where we've locked them up, then something in that process has gone wrong, and it will be in very, very rare circumstances that we would do that.

We need to look at working with children and their families and identify what works, 'cause even in the most -- families with the biggest challenges, something's working really well, and work with that family to build those strengths, give them the support that they need to build on the bits that are going well, lessen the bits that aren't going well, so that family units can stay together, and where that isn't possible, we provide care for children and young people which is the best possible care that we can do, but maintains those family and those community bonds, 'cause that's where children are from. That's their history. That's their heritage. That's where they go back to. And if

we don't support them to live well in that community and in that family, then we're not doing our service as parents.

Q. Now, obviously, Edinburgh Council has closed their own secure provision, but you recognise that there will be cases through the criminal justice system where young persons under 18 will require secure care, either for public safety or for perhaps their own --

A. Yeah.

Q. -- protection as well, ultimately, and the risks that they pose to themselves and others.

So you're not advocating that secure care is not a component of the system, you do need some form of care of that kind, but only probably, generally speaking, for those cases.

I would just like to ask you this: I mean, as you've pointed out, secure care now is only provided by charitable providers in Scotland. They've now faced the prospect of having a new intake of 16 to 18-year-olds that might previously have been in the young offenders system, and it does appear that historically -- apart from Edinburgh, perhaps -- local authorities, as they did with List D schools, set their face against having secure provision as part of their general provision for young people, and left it to the voluntary and

charitable sector to provide that provision.

I'd just ask you this: what do you think's going to happen in the future? Some people have got a rather, perhaps, optimistic view about how secure care might eventually, to some extent, wither on the vine, but, I mean, if that doesn't happen, there's an increased demand for places, what do you see as the future? Do you think that's all going to be charitable or private provision?

A. I think it would be unlikely that local authorities would move back into the space of providing their own secure care. Increasingly, local authorities are providing their own residential provision. So we're lucky in Edinburgh that we still have our own houses, and a number of them. Quite a lot of local authorities have not got that provision anymore, they've moved that into the private sector, and that's been a mistake because they haven't had enough of the right kind of provision. So local authorities are going back to opening up their own residential provision. I think it's unlikely they'd move into secure.

There might be situations where clusters of authorities will work together and look at secure provision, either through a secure children's home provision, but there are certainly authorities that are

working with their health colleagues to look at secure CAMHS type provision, mental health type provision, because that is a real gap in the system, and certainly in previous roles, I've been in consultation with neighbouring authorities and with my health partners around: should we create our own kind of tier 4 CAMHS provision for children that have got very complex mental health needs?

So I think that's a distinct possibility.

Q. I suppose that one way, perhaps, to at least some extent equate secure care with other forms of residential care would be to maybe move towards a Norwegian type of approach, where you're detained but that's all. That's the only right you lose. Within the actual four walls of the establishment, life is meant to be as normal as possible, with the sort of things you would find in a normal environment, except that you can't go out the front door.

Is that the way that you see it should happen if it's needed?

A. Absolutely. It should be -- the emphasis should be on the care. You know, that's -- the most important bit is the care. If we are understanding that children and young people end up in these circumstances because they've experienced significant trauma, retraumatising

a young person by putting them into an environment that doesn't care for them is not going to help.

Q. You tell us about the 1970s and how things were, and people were put in secure care, as we've discussed, for all manner of reasons, including children with significant mental health issues or complex problems, and to some extent that may still be a problem today because of lack of alternative facilities that are appropriate.

But it certainly seems from the McKinnon report that the culture of the 1970s was, in many respects, the prevailing culture within ESS until as late as 2019; would you agree?

A. Yes.

LADY SMITH: Amanda, when you emphasise care, are we really going back to the question you raised earlier that would come from the mouth of a child saying: 'What do you need to be able to know how to work with me?'

A. Yeah, I think we are. I think it's about knowing the children that we work for. You know, I always say to my social workers: you should know the favourite ice cream flavour and the shoe size of every child that you work for, because you should know about their life. You shouldn't -- that's why things like chronologies, which sound like a really kind of, you know, bureaucratic bit

of a file, are really important, because you need to understand the history.

That's why working with parents -- working with parents that might not necessarily even be part of a child's life. So, you know, we have more of an emphasis now on working with fathers who aren't necessarily living with the child. It's why understanding the dynamics of the family they're from is really important, understanding the community they're from is really important.

LADY SMITH: Knowing what that child is like and knowing what it would be like to be in that child's shoes and to be in Edinburgh's residential care; have I got that right?

A. Yeah, absolutely. And also understanding what love means to that child and how you can show them that they're loved and cared for in a way that is safe for them. Because for some of our children, you know, particularly for children that have been in an adoption breakdown, you know, a close family environment is really scary, and the kind of typical things that happen in a family are really scary 'cause that's not worked for them.

So it's absolutely understanding that. It is understanding, you know, what makes them feel loved,

safe and cared for, 'cause it's different for different children, as it is for all of us. You know, we all want different things out of life. So it's absolutely understanding that.

LADY SMITH: Thank you.

MR PEOPLES: I'm conscious of the time, but I'd just like to finish this section briefly. There's just a couple of things.

Apart from the culture of the 1970s being the culture within ESS in more recent times, there was in addition, I think -- and I think this is acknowledged now -- a senior management culture within children's services, and perhaps even within the broader council, that tolerated such a culture, knowing it to exist, and failing to do anything about it for whatever reason, whether through complacency, incompetence, or even deliberately refusing to deal with the problem. That's the situation, it would appear.

A. Yes, it is. Yeah.

Q. Just lastly on this matter: Howdenhall historically was an assessment centre. It started as a remand home in 1968, it converted to an assessment centre when remand homes were scrapped in 1971 and carried on being a multi-purpose place, including residential assessment, until maybe the mid-1980s.

Just on the question of assessment, it is a key part of care planning, but am I right in thinking that residential assessment centres are a thing of the past?

A. In closed conditions, yes. What lots of authorities have and we're considering is, as part of their Edge of Care service, you have a kind of emergency placement, and that typically operates over a weekend.

So if, as often happens, things get really heated in a family, and it's Friday night and a teenager leaves home and mum and dad aren't having the teenager back, then that's the circumstances in which a lot of children come into care in an emergency. What we don't want to do is bring children into care in those circumstances. What you normally need to do is to take the heat out of that whole situation and take that child back home and do some really intensive work with the family.

So what lots of authorities have is almost like a weekend placement, where children and young people come in for the weekend to take the heat out of that situation and then are supported to go back home, and there's intensive support to the family.

So it's not specifically an assessment centre, but it's more about -- it's part of their Edge of Care service.

Q. It's kind of the reverse of home leave at the weekend;

it is at home most of the week and --

A. Yeah, and we do have some children and young people that we do have a kind of shared care arrangement with, you know, that have short breaks because that's the thing that works best for their family.

LADY SMITH: Mr Peoples, I think we'll stop there for the lunch break, Amanda, and I'll sit again at 2.00. Thank you.

(1.00 pm)

(The luncheon adjournment)

(1.59 pm)

LADY SMITH: Welcome back, Amanda. Are you ready for us to carry on?

A. I am.

LADY SMITH: Thank you.

Mr Peoples.

MR PEOPLES: My Lady.

Amanda, I propose now to pick up some of the particular sort of themes or issues which you address in your statement. I'll come back to the file review maybe towards the end, because I think it's possibly an ongoing issue and I think I'll leave it until then.

A. Okay.

Q. You have a section in your statement headed 'Restraint/de-escalation', and I think you say at the

outset, at paragraph 73, that -- obviously restraint has been a theme in this case study, but you say:

'It is clear that at Howdenhall restraint and single separation were being used unnecessarily and inappropriately.'

I think that's the council's assessment, based on the whole evidence that has been presented and forms part of the case study, and, indeed, other material I think you've probably seen beyond.

What you also say, I think, is that while there was a -- we heard evidence that the CALM model was introduced at some point, maybe around the early 1990s, because I think before then it was maybe less clear that there was any form of restraint training, whether CALM or otherwise, you say that it's clear on the basis of Pauline McKinnon's report that it was not being implemented, I think you suggest, as intended, I think, at Howdenhall, and that some staff didn't appear to understand fully that it involved de-escalation.

Just on that, I think certainly there's a suggestion that perhaps to some extent some staff took the wrong message from it; that you could restrain and you should restrain, and as long as you use CALM, then that's okay, rather than perhaps focusing on the real message, which is: well, we don't want to restrain at all, and

certainly not prone restraints, unless it's absolutely necessary, and only where there's risk to the person or others that it should be contemplated.

So do you agree that seems to be at least one of the difficulties?

A. It does. I think it's -- I think it's been a misunderstanding of the model, that CALM isn't a restraint model. Restraint is part of a de-escalation model, but it's as you've just said: it shouldn't be seen as a restraint is going to happen, it's just at the point at which it happens; it should be that restraint shouldn't be happening and it's only in very exceptional circumstances that it happens.

So CALM's part of that and a really important part of it, but it is also about the kind of ethos of the house, which is why we did the work with Aberlour and Kibble about being a no-restraint organisation.

Q. I'll come to that in a moment.

In a sense, language can be useful. I mean, it might have been better to have called it 'de-escalation training', at the starting point, rather than focusing on the end point if necessary. I think it's been softened over the years to call it 'physical intervention', which is maybe a little euphemistic, but maybe they should have thought more clearly what sort of

training they were seeking to introduce, and that might have sent a better message.

Do you agree the language can be important?

A. I think it's about the culture. I think it's about the culture in which it's used. If -- any training, no matter how good it is, if that's being used in a culture where it's about command and control and not about care, then it's never going to be used in the right way. You know, the way that we work now is, as we talked about earlier today, we're trauma informed, you know, we're about care first.

Q. So you feel that even with training, if the culture that's there already is embedded, it's going to be very difficult to make the training effective and make people apply it when they're used to doing things a different way?

A. Training is part of the way of changing culture, and culture is part of the way that training operates. So you have to do it all at the same time. You know, a training package isn't going to shift systemic bad practice.

Q. I think there's probably research that says that people go for training, but maybe less than -- certainly a good deal less than 50 per cent come back and apply the training.

A. Yeah.
Q. They do it because they have to, but that doesn't mean it's embedded or absorbed and applied in practice. I think that's a real issue, is it not?
A. I think it is, and that's why it's got to be part of a whole system change.
Q. You do say that there was a further training programme in light of the McKinnon report, to some extent interrupted or disrupted by the onset of the COVID situation.

You also mentioned, and you spoke about this earlier this morning, that City of Edinburgh Council had joined forces with Kibble and Aberlour -- is this the Aberlour Trust?
A. Yeah.
Q. Yes -- in a pilot scheme exploring -- and it may well be an aspiration -- no-restraint organisation, and you say that through the pilot, use of restraint dropped significantly and, indeed, there was one point where there had been no restraints in the residential estate for a six-month period.

Now, just one thing. Can you maybe identify what, as a result of the engagement of the pilot scheme, was being done differently so as to reduce or, in some cases, eliminate for a time the use of restraint?

A. I mean, again, it's part of the whole system improvement, which is around changing the culture and changing the way that we practice towards being trauma informed and towards operating differently, and the reduction in restraints has continued. We don't have prone restraints at all.

Q. Is that because they're not permitted?

A. Yeah.

Q. They're banned?

A. We wouldn't -- I would never expect a prone restraint to happen. I can't understand a circumstance in which my residential staff would be involved in a prone restraint. It's -- something's gone desperately wrong if that happens. So -- and we haven't had any in the last year.

Q. But I think -- and you can tell me if this is not the position now, but did CALM training and, indeed, CALM training now still conceive of the possibility of a prone restraint?

A. We would not expect it to happen within Edinburgh.

Q. Whatever CALM says?

A. Yeah. It's -- for those reasons, why -- I can't conceive of a circumstance in which a prone restraint would be appropriate.

To give you an example, we had 35 restraints in

2021, and in 2024, across all of the houses, we had six.
Q. And how many houses are we talking about?
A. Eight.
Q. And how many people in these houses?
A. Between five and six in each house.
Q. Okay.
A. And those six related to two specific young people.
Q. Okay.

Do I take it that the use of restraint, even if it's not prone restraint, is something that is not strictly prohibited, that there are occasions when some form of physical intervention, if I use a more neutral term, is required, and that that does happen from time to time?
A. It does, but it's very rare, and when we talk about the six, that's anything from holding a child's elbow. So, you know, it's any time that you're going to have any kind of physical intervention with a child.

But in most circumstances, you would remove other people and yourself so that that child can do whatever that child needs to do. It's only if that child is in imminent danger of injuring themselves or imminently injuring somebody else that you would intervene, and for the shortest possible period.
Q. I suppose it's very easy to be wise in hindsight, but common sense might suggest that if someone is

challenging and being aggressive, that that's not the best time to reason with them or try and take hold of them in any way, because it might produce the wrong outcome?

A. Absolutely. And also, we have really detailed risk assessments about each of our children now, and part of that is around understanding what's likely to trigger them, understanding what is likely to put them in a situation where they're becoming dysregulated, and how you can best de-escalate that, and we check those as part of our audits.

Q. Well, I think one of our witnesses -- it was Jane Carmichael -- said that it has to be understood that all challenging behaviour is a form of communication indicating that the young person has some form of unmet need. You probably agree with that?

A. Yes.

Q. That sounds like good advice.

LADY SMITH: I think you made that observation before lunch.

A. Yeah, absolutely. I think, you know, some of our young people, because of their experiences, can't verbalise what's going on for them, so -- but they will tell you, they just tell you in different ways, and we've got to be really tuned in to how it is that they're communicating and what they're communicating.

So if a child's dysregulating on a regular basis, they're telling you something. They're telling you something's not okay with their life. So it's our job to get to the bottom of what it is that's not okay and help them with that.

MR PEOPLES: So the other part of that, then, I suppose, from the point of view of the residential care workers who have to manage these behaviours at times, is that the staff who are caring for the young persons must strive to understand each young person's particular triggers and seek, perhaps, by addressing through relationship-building and appropriate programmes, the underlying cause or causes of the behaviours. Is that sound theory?

A. Yeah, and it's as we talked about before lunch; it's knowing that young person. It's having a relationship with that young person. You know, it's knowing what's going on in their life and understanding how you can best be their parent.

Q. I mean, we have heard, I think, from one local authority who says they do have a no-restraint policy. I think to many of us, they would think that, given the complexities of some of the young people and their backgrounds, that that may be indeed aspirational, but not necessarily achievable in practice. You can

minimise as much as possible, but can you really reach a point where you would never have a need to restrain a young person? It sounds almost impossible to say that, do you accept?

A. I think, again, it's in very exceptional circumstances. It's where there's a really imminent and significant risk that you'd physically intervene.

Q. Yes.

You give a number of reasons why historically, perhaps, there were too many restraints, unnecessary and inappropriate, and you give a number of factors, including poor recruitment practices, no doubt lack of training and so forth, and to some extent, use of temporary staff who didn't maybe have any form of training or understand the child concerned and so forth.

Also, I think the way you put it is at paragraph 79, which in a nutshell is that the impression that I think you formed from the whole evidence is of a culture which focused on control to the detriment of care.

A. Yeah.

Q. You do mention at this point -- and it's an issue that we've had evidence about -- it's the matter of what's described as 'toy fighting'. I think that's an expression we find in earlier policy statements, and that clearly has been the subject of some evidence.

It does appear that there is documentation to show that it wasn't banned, it could be seen as acceptable policy, albeit subject to any guidance in relation to its use, but you tell us that whatever the position was in the 1990s and early 2000s -- because I think we know -- we've got some documentation from the council that shows that by 2007, but possibly earlier -- probably earlier -- it had been banned.

A. Yeah.

Q. So there was no latitude to engage in toy fighting, staff and young people.

You say it's certainly not an acceptable practice now. So, I mean, that is policy?

A. Absolutely.

Q. Just on policy now, can I ask you this, because I'm not sure it's covered by the various topics and themes that you've commented on.

In the past, we've had evidence of staff members -- and this isn't unique to Howdenhall or St Katharine's -- taking young people to their own homes. Indeed, we've heard evidence that says that that, in principle, can be a good thing and it normalises the experiences of young people, in contrast, at least, to the care setup in those days, and you'll be aware of that evidence.

I just wanted to know from you: what is the current

policy about staff taking young people to their own homes? Is that, like toy fighting, an absolute no?

A. It's not an absolute no. It would be very unusual for it to happen, but there are circumstances in which it could be part of a child's care plan. It'd have to be part of a child's care plan. It would have to be risk assessed. It'd have to be agreed. And it's promoted a debate amongst the team around: when might it be acceptable? And the example that we could come up with was: if a young person's got a really strong relationship with a member of staff who, for example, has been off sick for a significant period of time and, you know, maybe isn't well enough to come back to work, then it would be appropriate for that young person to be supported to go and visit that member of staff.

Because one of the things that happens for our kids is that they lose people in their lives really suddenly. You know, a lot of -- if you talk to care experienced children, one of the biggest things they tell you about is somebody who was really important to them just vanished and they don't know what happened and they don't know where they are. It's often why they seek access to records because they want to know what happened to people.

So if you've got a person, a member of staff, who's

got a really solid relationship with a young person, you'd have to then look at: how do you make them not just vanish from their life? And in those circumstances, I can see that a planned visit -- a supervised visit to their house would be an acceptable thing to do.

Q. Okay, but you don't see that as a very common situation.

A. No.

Q. Maybe the other side of the coin is that perhaps there's less need than in the days when St Katharine's/Howdenhall were managed in the 1990s, because, as I understand it, the whole idea is to create in your houses something as near as possible to a home, and therefore you are getting normality, so far as it's possible to achieve that, in a group setting.

A. Yeah, and the teams have worked really hard on making the houses into homes, you know, the physical environment, but just the way things are done. So, you know, moving away from a kind of institutional having a cook that produces food to, you know, growing the food in the back garden and then cooking it with the young people, you know, so that that's what you'd do in your own house.

It's the example I gave of the barbecues before. You know, you have your family round for a barbecue. So

the children's birth families and other children that might have lived in that house come back, so that that becomes their home and it's a homely environment in which they feel safe and, crucially, in which they feel loved.

Q. Now, there is perhaps a more complex issue of the issue of physical contact between care staff and young people in their care.

We've heard evidence from some applicants about their need, their individual need for affection and contact, hugs, whatever, and in some ways, that has turned out to be an unfortunate experience for some, because it's been picked on and seized by people who have abused them. We've seen examples of that in this chapter and, indeed, other chapters of this case study.

I'd be interested in your views, because you've mentioned sort of nurturing, love, in The Promise sense, if you like, that seems to be something that's a central concept of The Promise, and yet this is quite a difficult term to use in the context of a care setting, where these individuals who are carers are not parents or related to the young person. They may not be in contact with them for that long, in some cases. You still want to create a nurturing, homely environment, but what is the current position, certainly within

Edinburgh Council, with regard to physical contact between care staff and young people? Can you help us with that?

A. Yeah. I mean, they are parents, they're corporate parents, and they're in a role that is acting as parents, so they need to see themselves as parents. I think that's really important. And it is a thorny issue, and it has to be led by the child.

For some young people -- you know, we've talked this morning about: 'What do you need to know to look after me properly?' For some young people, physical affection is really, really important, and it has to be part of their care plan and it has to be in a way that's safe.

So, you know, we have to work with children around how it best works for them, because for some young people, they need to learn that physical touch can be a safe thing, because they're going to need that for, you know, growing up into adults that can maintain adult relationships, and it is important. For others, it's an absolute no-no and it's not something that would be right for them at that point in time. And we've got to talk about it.

But we also have to talk about: how do you show love in an institutional system? Because, you know, if we look at Maslow's Hierarchy of Needs, the thing that you

need most, after you've had food and shelter and warmth, is you need love, and that's our job as parents, to show those children that they're worthy of being loved.

Q. It's not maybe the word that everyone would like to use, because it may be that it's a risky message to send, that young people need love from their carers.

Now, you've given all the reasons why that is important, but is 'love' the best expression?

A. Yeah, I think it's absolutely the right expression.

Q. Yes.

A. It's important that when we come to work, we come to work as parents of those children. You know, I consider myself to be the corporate parent of -- the corporate mum of, you know, the best part of a thousand children and young people. It's really, really important that that's the mentality that everybody comes to work with, and that you treat those young people as you would want your own child to be treated.

Q. Now, can I move on to another matter: recruitment and staffing.

I'm not going to spend too long on this, because I think you set it out and you've said that there was a review of recruitment practices, and you tell us that, certainly in relation to recruitment of staff for individual houses, there is a new way of doing things,

that you're really looking to match the individual to the particular house, rather than simply do some sort of broader exercise of whether they'd be suitable for the type of role that's advertised. Is that the broad approach now?

A. Yeah. So what we do now, each house has a manager, and previously there was one manager between two houses, and that manager then recruits for their own house. So they don't go through -- they don't wait for a centralised recruitment to happen. So what that means is that we recruit as soon as we get a vacancy, so that there's not -- we're not using temporary staff, but also we don't move people between houses.

So if a member of staff from one of our houses wants to go and work at another house, then they have to go through an interview process to move to that other house. They can't just move to other houses.

Q. Because I think, historically, transfers were quite commonly done just because either there was a need one place, for whatever reason, or someone wanted a transfer, and it just went through fairly automatically; is that --

A. Well, they worked for a residential service, rather than a particular house, so people moved between, and one of the problems that you can see in some of the records is

you can't see who was on a shift and who was working there at a particular time because they worked for the service, rather than working in an individual establishment.

Q. I meant to ask you this earlier. We're constantly on children's services. You sometimes use the expression 'residential services'. In the context of the Social Work Department, is 'residential services' a broader expression, covering services for adults as well as --

A. No. No, no, it's just children's.

Q. So residential -- is that just the equivalent of children's services? Are they interchangeable?

A. Children's services is the whole lot, and then within that you've got residential, you've got family-based care, you've got social work services.

Q. I see, yes. So it's a subset of children's services, rather than a more generic term?

A. Yeah.

Q. I follow.

Now, just on the question -- there's also the issue of single separation, which you mentioned, and I think Pauline McKinnon made some point about the confusion between time away or time out and single separation and the need for some degree of clarity between the two different procedures.

I just want to know this: single separation or isolation -- people use different terms -- or segregation, is that something that still happens in residential houses?

A. No, we don't have a single separation policy anymore.

Q. No.

A. That was specifically within secure.

Q. So that, again, is not something that -- if you talk about what we would have said a 'children's home', which might be called a 'house' now, that just isn't something that is contemplated?

A. No.

Q. If someone was found to have taken a child to their room and if it's possible to lock that room -- and I don't know whether that's possible.

A. It's not.

Q. No even if they took them to their room as a form of isolation, would that be a --

A. No.

Q. -- breach of discipline or code?

A. Yeah, yeah, it's not okay.

Q. Yes.

A. I mean, you might go with a child to their room and sit with them and have a conversation and help them calm down and help them do something else, but you wouldn't

seclude a child in their room.

Q. Okay.

LADY SMITH: Why not? I'm not suggesting you should, I'm just wondering what the reasoning is that's produced that as a policy?

A. Because you wouldn't want their room to be a punishment for them. I think particularly in group houses, their room's really -- their room being their safe space is really, really important. So if their room becomes a place where they're punished, it's never going to be a safe place. It can be a place where they go and calm down. So if -- for them taking themselves out of a situation and go and sit in their room and playing on a game or reading or whatever, that's an appropriate way of doing that. But to be forced to go and be on your own in a room where you can't leave is depriving somebody's liberty, and it's not creating a safe space for them.

LADY SMITH: Thank you.

Mr Peoples.

MR PEOPLES: Now, just moving on, there's a section about 'Policies, procedures & record keeping' from paragraph 85.

I think you make the point that it's not enough just to have policies and procedures and making sure they're

up to date and compliant with legislation. I think all too often in the past, people have taken refuge in that fact: 'Oh, well, we've got systems, we've got policies, so everything's okay so far as we're concerned, we're doing all the right things'. But you say the other aspect is whether people understand and follow them. That's the issue of whether they comply in practice and how you ensure that.

Now, we've had a long discussion this morning about that, so I'm not going to labour it, but that's something that maybe was missing in the past. There was maybe too much focus on saying, 'Well, we have a policy, we have a procedure, and that's good enough', and maybe if the auditing mechanisms or the oversight mechanisms weren't working as they should have done, people at the top might be getting reports suggesting all is well, when plainly it wasn't well.

A. Erm, yeah, possibly, but it's part of a context in which -- it's the thing about being a learning organisation, you know, that you're going to change your policies and procedures 'cause practice changes. So they should always be live documents. The world moves on research. You know, we do research. We learn about new things. We change the way we practise. And when we do that, we produce different policies and procedures

and processes. But we also train people and we have different auditing systems.

So it's a kind of continuous -- it's that continuous system of improvement that's really important.

Q. Yes.

I'm reminded, I think, that one of the things that maybe is wise advice from the significant case review for those in the business of making policy and producing guidance is that practitioners and front-line staff can be swamped by the amount that's produced and that that can be counterproductive. I think that's not just something we've heard in this case study; it is something that has been explored in other case studies and chapters.

Can you see the point, that you get overload? People are constantly producing large manuals, big guidance, different guidance each month, and the practitioner or front-line member of staff or even the manager could be forgiven for thinking, 'Goodness me, not just another piece of guidance, and how does that fit in with what I've already got on the whole bookshelf in my room?'

Now, do you take the point of that, that you've got to be careful that you don't have too much?

A. I think if you're in a system where you're -- it's kind

of your rules are your policies and you operate the policies to the letter of the policy and there's nothing else within that system, then yes. But if you're in a proper system that's about learning, then practice evolves, and practitioners know practice evolves.

So it isn't all of a sudden there's a new policy on a Tuesday afternoon; it's that we are talking about: how do we do this differently? How do we do this better? What does that look like? And then the policy forms that.

So if you use child exploitation as an example, you know, one of the things that my team are doing as we speak now is that they're looking -- having a discussion around the work that we're doing around child exploitation and what do we do next and how do we move that forward.

Now, that will come with a revision of the policies around child exploitation, but they don't come from nowhere. You know, they come from that debate, that conversation, looking at research, looking at other places that have got really good systems and processes. So it's part of an evolution of practice, and it's part of a professional curiosity around wanting to be better.

Q. I get that, and I understand the need for the discussion and doing the homework. But ultimately, when it's

translated to the front line or practice, the practitioner might not be able to have the debates, discussions or necessarily to see it all in such clarity as you may see it, and maybe they need to say, 'Well, this is what we have at present, you're introducing something new, explain to me what the significant difference is to what you've sent me before', rather than saying, 'Here's a new set of guidance on a general topic', whether it's restraint, physical contact, whatever, and maybe that's to understand the needs of a busy practitioner who also doesn't want to end up not being able to see the wood for the trees.

Do you get the point?

A. I get the point, but it isn't about just sending a policy out to people. It is about that kind of whole system of learning.

Our caseloads are really reasonable. You know, we've had a 33 per cent reduction in the amount of open cases over the last year. We work on an average caseload of 15, which is a very reasonable caseload.

Social workers are registered. As part of their registration, they're expected to do ongoing professional development and learning, and the majority of social workers want to do that, you know. Part of developing their practice is exciting.

So, you know, I have practitioners that want to lead on particular topics and particular areas 'cause they're really interested and they want to be at the forefront of better practice.

Q. I'm just suggesting to you that to get the message across, apart from issuing guidance -- and maybe you're telling me you do all of this, but it's just to give people some sense of stability about the job they're doing and not feel that they're constantly having to react to albeit a dynamic situation, a developing practice, but you still don't want to get them walking on eggshells thinking, 'Well, was what I was doing yesterday now, although it may have been policy, is it now wrong?' You can see how they could be left in a tricky situation, particularly if they're used to not necessarily a bad practice, but one that needs to be changed.

Do you take that on board? No?

A. I can understand where you're coming from, but I think, you know, if you've got a system where you've got good management oversight, you've got good supervision, you've got access to learning, you've got, you know, access to research through appropriate links to universities, you've got new practitioners coming in with new ideas -- social work, in essence, is about

change. You know, we work with people to change. So social workers have to be open to change and accept change. It's kind of what we do for a living.

Q. But they're not all people that have necessarily gone through a university education or have degree qualifications. I mean, certainly people, front-line staff, they do now have to have basic qualifications, but some don't have more than that. It's not a reflection on them, but it may be that for them to take on board the key messages, there has to be thought given to whether they can absorb them in the same way as a manager, for example.

A. Yeah, which is why it's part of that whole system of training, development, access to research, access to supervision, access to team meetings. You know, people learn in different ways. Some people are visual learners, some people are experiential learners. It's making sure that all of that's available to staff.

Q. Now, you have a section on whistleblowing, but I'm fairly confident we've probably covered that --

LADY SMITH: I think we did.

MR PEOPLES: -- this morning, so I'm not going to go back to that.

You've mentioned standard of education from 107 and, again, you spoke about that as a gap area, and you're

addressing it in a more focused way in the revised plan I think that will be produced for June.

You've talked about external visits, and we've discussed that, so I don't think we need to go back to that, and you've talked about elected members being linked to children's houses so that they have a direct interest in particular residential houses in Edinburgh.

I'm not really planning to go back to the comments on Pauline McKinnon's statement. I put them to her and we read them.

The only thing is that, I mean, apart from you recognising that she did an excellent job, you are disappointed with the lack of supervision and support during the investigation, and how she felt about what was happening to her as an investigating officer -- not a whistleblower, an investigating officer -- and you say that you can, I think, sympathise, because in trying to change practice, you have encountered some difficulties, resistance, and have had to battle at times to try and achieve changes in the sort of areas that these earlier reports have considered.

That is the reality --

LADY SMITH: You deal with this at paragraph 118.

A. Yeah. I mean, absolutely. I would, again, like to thank Pauline and praise Pauline for the work that she

did. Change and effecting change here is really difficult. You know, we've talked about it being a very entrenched culture. Changing culture is hard. It's -- you know, I've got some brilliant staff who have worked really, really hard to make the changes that we've made and continue to make the changes, but it is hard work here.

LADY SMITH: One thing you say there, Amanda, is that:

'As a female who has come in to [Edinburgh Council] and has tried to change practice for the better I can say it is extremely hard at times.'

Tell me a little more about that.

A. I think there's been a pattern of the people that have raised their concerns throughout this whole process have typically been women that have raised the concerns, and there's been, you know, previous reports that have mentioned the misogynistic culture, mentioned the old boys network within the council, so that's a particular context. You know, when I came -- and I'm an experienced director. I've done this in a lot of places. You know, when I came and started to effect changes, there was resistance. But there were also comments like, 'Well, this is the old girls network that's coming now to make the changes'. So, erm, yeah, you know, there are definitely elements that were

misogynistic as part of that process.

I think that's very different now. I think there is a real shift in culture and an acceleration in that cultural change, and a very different senior leadership team now. The corporate leadership team of the council is predominantly women now, which, you know, has made a big shift, and I think it does feel -- if I reflect back on the place I came to three years ago and the place I work now, it feels like a very different place now, and it's a much more comfortable place to be now.

LADY SMITH: Thank you.

Mr Peoples.

MR PEOPLES: Comfortable, but not perfect, because --

A. It's not perfect.

Q. Because I think you certainly suggest in those paragraphs, 118 and 119, that there are times when it's still challenging to obtain information, degrees of resistance, and some discernible reluctance to change or scrutiny, and you're still experiencing that at times?

A. Yes.

Q. So it's a lot better, but it's not perfect.

A. It's not perfect, and I would say if anybody that sits in my chair ever tells you that their services are perfect, they're, erm, somewhat naive.

Q. No, but I got the impression from -- I think the council

provided us with recent update progress reports, and we're certainly not going to look at those today, but one thing that maybe comes out is occasionally remarks like, 'Progress hasn't been as quick as we expected'.

A. Yes.

Q. Now, I was just wondering whether we tie that into some of these being the reasons for that, or not?

A. There's a range of different reasons for some of those. So, you know, one of the things that's on the improvement plan is around recruitment, you know, and particularly in shortage areas, it's really difficult. You know, social work is a shortage area to recruit to. So, you know, we have an extensive recruitment process, we put a lot of work into it, but it's still hard to fill all the vacancies that you would want to fill. So some of those areas take longer.

Q. I get that, but in part, could it also be due to some of these factors, that you're still getting at least some degree of resistance to change?

A. Yeah. Yeah, absolutely. Change is difficult. Change is really difficult, and there will always be some people that resist it and resist it hard.

Q. Well, I suppose if you're used to one normality, trying to have a new normality or a new culture can be difficult?

A. Yeah.
Q. 'Disciplinaries' is another section that you -- and I think we've --
LADY SMITH: Just one question, still on changes and the implementation of change, for example in implementing the action plan.
Are you able to tell me whether the existence and work of this Inquiry has had any effect on that?
A. Erm, I think it's been really helpful to go back through all of the historic practices that we've done in kind of one go, if you like. That's been really helpful, to do that, and reflect on what has happened and why it happened, and I think it's really important for organisations to build on the positives and look forward and try and find a new future, but it is also really important for them to understand how they got to where they were in the first place, and I think this process has been really helpful for that.
You know, it's been really difficult at times to go through the history --
LADY SMITH: I'm sure it has.
A. -- because the history is not great. In fact, it's awful in a number of places. But I do think that's been very helpful, to think about why we are where we are and how we don't get where we were ever again. I think

that's been really helpful.

LADY SMITH: Good.

A. I think it's also been helpful, as we've gone through this case study, to think about some of the examples we've talked about today. So, you know, when is it okay for a child to go to a member of staff's house? We've had more live debates about some of that than we possibly would have done at other points in time. So, yeah, I think it's helpful.

And I think it's also really helpful to be able to have conversations about: what do we collectively do that might put us in a position where this is less likely to happen in the future?

So, you know, we're going to come on to it in a while, but things like the LADO, things like that are systemic things that we could collectively do that make this less likely to happen in the future, and that, of course, is really important.

LADY SMITH: Thank you. Thank you, Amanda.

Mr Peoples.

MR PEOPLES: Can I move on to 'Disciplinaries', and I don't want to spend too much on it today -- I think, at 127, you express a degree of surprise, I think, perhaps arising out of the McKinnon report, that you're maybe surprised that no member of staff was dismissed?

A. It's complex to get the required evidence that you need to take forward disciplinary action. You know, people have employment rights as well. Employment law exists. So it's a complex and delicate process.

We have taken action against everybody where there is a case to answer to, and we're continuing to go through a number of our historic files, and where there are examples of poor practice, we're working with HR to look at whether or not we need to go forward with that. And we've also secured a second check on that, in that we've got an external legal firm to do another look at any of those cases as well.

Q. The other matter -- and this isn't maybe constrained by employment legislation in a unionised environment in the public sector, where we all know it's very difficult to get rid of an employee -- you're extremely surprised that, following the referral to Police Scotland of some of the McKinnon material, that nothing came of that and the investigation was closed.

A. I am surprised that there haven't been any prosecutions. I think one of the challenges is that a number of young people -- it's that thing about what -- how do young people communicate? So a number of young people who were in very difficult circumstances in our care were also being criminalised for their behaviour, because

their distressed behaviour became criminalised. So those young people then make very difficult witnesses, and I think that's maybe part of the reason, and that -- that's a real problem.

Q. Okay. Just picking up the next point about the Care Inspectorate and internal inspections.

You make the point in 132 -- and we've spoken about this -- that the Care Inspectorate reports, which I think were described even in the SCR as generally favourable, didn't pick up the sort of problems that were highlighted by Pauline McKinnon's much more comprehensive report, and even within the inspectors' reports, there are some degrees of inconsistency at times.

So it does appear, from what you're saying at 135, that you've had conversations with the Care Inspectorate about their methodology, and first of all, I think you take the point that if you want to speak to children in a setting where they may be frightened or are frightened, they're hardly likely to tell you that, and that perhaps also the way in which the inspectorate have undertaken their task might need some revision and rethinking.

Do you still think that?

A. And Care Inspectorate are looking at the way that they

inspect and looking at, you know, their whole inspection framework, as most inspectorates do. You know, the point I made about social work practice changes and inspection practice has to change to go alongside it. So some of my team were at a meeting with the Care Inspectorate at the end of last week where they're looking at a new methodology for inspection.

So, you know, they're very receptive to think about new ways and better ways of inspecting.

Q. Can I pick up the point about LADO. I said I would come back to it. It's at 147 to 153 of your statement, where you believe that this is an area where the English system can offer a better solution, in that there is a requirement on English local authorities to have a local authority designated officer, or 'LADO' for short. It's a statutory role, and that individual is responsible for overseeing concerns, allegations or incidents involving individuals working with children and young people, and it involves ensuring that the concerns are handled fairly, safeguarding the child's welfare at the same time, and also ensuring that individuals are not unfairly treated during the process. They are not themselves an investigating body, but they can assist and provide guidance on safeguarding and employment law procedures and oversee the process, and

are involved from the start to finish.

Also, you say at 149, an important part of their role is to spot patterns and complaints or concerns and instigate further investigation or action if that is considered appropriate.

So I take it that you would be advocating something similar, and I think you're actually trying to create a LADO type post within Edinburgh?

A. Yeah. We've got -- part of the budget proposals that are going to committee on 4 February are to fund a LADO post for the city. Obviously, the legislation is different, so it won't have the statutory standing that it has, but in my experience, it's just really helpful to have that single point of contact that deals with all allegations against people in a position of trust. So they deal with allegations against partner agencies as well.

And, you know, the issue that we've talked about a lot today about not seeing patterns, not seeing consistent issues, a LADO makes it less likely that you're going to miss that. It's never going to be a perfect system, but it's another effective check and balance.

Some large authorities have more than one, so you have to be really careful then that they work as a unit

and you don't have things that fall between them, you know, and if you're in a large authority, one person -- it's a lot for one person to do it. But it goes with a system and a process around LADO that means that all the information is in the same place, it's all stored in the same format. It just makes a lot of the issues that we've talked about through this case study significantly less likely.

So I'm hopeful that if the budget gets agreed as it is, then we'll be going out to recruitment for that post at the end of February.

Q. Just on the matter of the Care Inspectorate, we've touched on this already, but you certainly compare an Ofsted inspection with a Care Inspectorate inspection, and I think you believe from your experience that the Ofsted inspection is a much more rigorous process and involves, perhaps, seeing and speaking to more people and looking in more detail at relevant records. Indeed, there have been occasions where children have disclosed abuse, and Ofsted had powers to challenge decisions if they thought a child in care is in a care setting that's not appropriate.

Now, you do qualify that at 152, and I know why you're doing that, because it's come under some criticism because of a particular case where a head

teacher took her own life following a particular inspection or an assessment that was made. I think there are now plans down south to maybe remove or soften some of the rigour. I'm not going to get into a debate about that.

But do you still feel, generally speaking, though, that the Care Inspectorate has something to learn from the Ofsted approach?

A. I think there are bits in both systems, that if you marry the two together, you'd have, like, you know, a really perfect system.

One of the difficulties with the Ofsted system is it becomes such a part of services' lives that I remember a social worker saying to me once, when I asked them why they were doing something as part of an audit, they said, 'Because Ofsted are coming', and that should never be the answer. The answer should always be because it's the right thing to do for the child, and if you're doing the right thing for the child, then Ofsted should pick that up. So there are some challenges with it.

The reason that I think there are lessons to be learned is that one of the things that Ofsted require is a particular data set, so particular management information data that is child-level data. Now, the Care Inspectorate are looking at that. I think that's

really important. Some of the challenges that we've had in Edinburgh, like children not having up-to-date assessments, children not having up-to-date care plans, wouldn't have happened if we'd have had what's called Annex A, which is a child-level data set, because what you do typically is you run that data set every fortnight and you cleanse that data. So you wouldn't have a child that didn't have a care plan because you would pick it up through the data and through the system. We wouldn't have had SWIFT for as long as we have if you'd have had to run that, because you couldn't run that through SWIFT. So, you know, there are some kind of checks and balances in that system that are stronger.

There's a very strong focus on audit and triangulated audit in an Ofsted system. So you are expected to audit a percentage of your cases. You're expected to report on that. You are expected to triangulate that.

There's -- it goes hand in hand with a sector-led improvement system as well, which again is something that is happening here as well and is strong here. But that is about, you know, where you get peers to come and look at parts of your system and you do peer challenge.

So here we have collaborative challenge, and we've

used it very well in education here, and I think we can make more of that on the social work and social care side and start to do more of that. So we look at each other's services and we challenge each other on those services as well.

Q. But I take it the Care Inspectorate are listening?

A. Yeah, I think they are. Well, there was a meeting last week where they're talking about a different way of delivering inspection.

Q. Now, can I go back to the file review. It kind of dovetails with the child sexual exploitation and exploitation generally that you talk about, so I'll start with the file review at paragraph 54.

Obviously Pauline McKinnon reviewed 30 cases, and I think that then there was a dip sampling in early 2023 of other records, because I think you were not satisfied that everything that was in fact a complaint or allegation may have been logged as such. I think that the results of that dip sample convinced you that it was necessary to commission a review of all the historical files for Howdenhall, and that's a process, I think, that's ongoing, is it?

You've employed, as you tell us at paragraph 57, an independent social worker, who's not an employee of City of Edinburgh Council, with considerable experience in

the subject of what's described as network abuse, and that she is involved in assisting in that process.

A. She is.

Q. And that's a work in progress?

A. Yeah. So --

Q. And -- sorry, yes, go on?

A. Yeah. So what happened was there were 30 children originally identified in the work that Pauline did, and that was the 30 children that had made a complaint. So the question had to be asked: were there children that had made allegations but they hadn't been caught through the complaint system? So that's what prompted the further review, which is the review that Josie Lee did. What she did was start to look at files, do file sampling, and also look at keywords in files, and from that, it became apparent that there was a more extensive -- there was more extensive restraint that had been happening particularly that we needed to pick up and we needed to look at. So then we decided we were going to review all of the files of all of the children that were in secure for a particular period in time. So that was 280 plus files.

What then happened is as you start to review that file, then you have children talking about them being involved with other children and young people who might

not have been part of that original sample. So then you go and review their file. So it then kind of develops other avenues.

So we are expanding the team. We're going to bring two more people into the team so that we can do this work a wee bit quicker.

Q. The review, therefore, isn't necessarily confined to children who were at Howdenhall because, because of what you've found, you're going to review a wider set of files of Edinburgh children who were in care?

A. Yeah.

Q. As you say, the work is ongoing at 58, and I don't want to go into too much of this, but there was sufficient concern, I think, that the matter was referred to the police for some form of review or investigation, which is ongoing, and that's a current situation?

A. It is.

Q. I think you tell us that that really includes concerns in relation to children who were in care, both at ESS and other houses in Edinburgh, and also children who were in the community?

A. Yes.

Q. Now, can I just ask you this: I don't want the detail, but do the concerns, without going into detail at this stage, include concerns relating to children and young

persons in the care, in the residential care of the City of Edinburgh Council, when they were outside of their care setting, for example on leave or home leave, including concerns about possible child sexual exploitation at such times by groups of older adults? Is that one of the aspects of this review and investigation?

A. It is one of the aspects of the review.

Q. Because that's an area that I think has not historically been addressed really at all, and I think that's why you, I think, have a section where you talk generally about exploitation, which is, I think, an area you have taken an interest in, and you tell us a bit about what's happening now. I just was interested in that.

It starts at 141.

A. Yeah.

Q. I think this ties in with what we've just been talking about. You say at 141, your impression is that:

'... the approach to Child Sexual Exploitation ... in Scotland is not as evolved as it is in England. That is not just within local authorities but nationally.'

You talk about the City of Edinburgh Council being involved or working with Action for Children on what's called the Sidestep project, aiming to divert young people away from getting involved in organised crime.

Indeed, you tell us that you did provide evidence to Alexis Jay's review into criminal exploitation of children.

Then you say:

'In the field of criminal and sexual exploitation [City of Edinburgh Council] started to adopt Contextual Safeguarding approaches formally in July 2022 through a pilot project ... which ran until June 2023.'

Can you just try and explain the general essence of what contextual safeguarding is?

A. Yeah. So the idea of contextual -- the child protection system traditionally is predicated on the idea that children are abused or harmed within their family, typically. So, you know, you'll place a child's name on the child protection register; the plan normally involves their family.

What we now know is that that's not only the way that children are hurt or harmed, and so we've come to understand that some abuse happens in a particular context, in a particular community, in a particular setting. So we've developed approaches around contextual safeguarding, and the concept of contextual safeguarding comes from extra-familial harm that happens in a particular area, and the way that you manage that is different than the traditional safeguarding

processes.

So in a contextual safeguarding approach, you have really tight information sharing with your partners, because what you're sharing is not just information about individual children; you're sharing information about locations, about systems, about processes. So if you look at some of the examples down south -- which is why down south I think it's more evolved, 'cause they've had Rochdale, Rotherham, they've had those big kind of network investigations. What you typically have is what you'd call a problem profile. So you understand in an area: where are the takeaways? Where are the taxi firms? Where are the hotels? Where are the transport routes that children are being exploited within, and how is that happening? And you share that information really tightly across the system with your partners.

You also then typically have a child-level process, which is where you've got children that you're worried about, so children that are going missing, for example, on a regular basis. You would discuss those children regularly as part of a multi-agency process. You'd understand where they're going, who they're with. So you map that. So you have lots of sociograms about: who does that child associate with and who were they there with, so that you've got a real picture of what's

happening.

Then you use the tools and powers that are open to all of you as a safeguarding network to disrupt and end this activity. So you wouldn't take a child and put them in secure care to take them out of that situation. If you'd got particular takeaways, for example, where you knew that abuse was happening, your colleagues in food hygiene may go in and disrupt that activity. You may use your licensing powers to disrupt transport activity. You might work with your nighttime economy sector to make them more aware of what child exploitation looks like and make sure that they're stopping it and preventing it. So it's a different way of practising.

Central to it as well is talking to groups of young people about what they feel like in their community and where do they feel safe and where do they not feel safe. So part of the Sidestep work has been doing that with a group of young people around, you know, where are you feeling safe? Where are you not? How do we manage that?

And the last part of it is really working with young people and groups of young people to help exploited young people recognise that they're being exploited, because lots of young people that are exploited don't

understand their victimhood. They don't like what's happening, but because people that exploit children are quite skilled at being exploitative, they can often convince children that it's a loving relationship, that they're their boyfriend, et cetera, et cetera. So what works very well with those young people is networks of young people who have been through that and come out the other side, helping young people to experience that they are actually a victim and they need support and help to get out of it.

And finally, the last bit is that it's not -- where it works best, it's not just children's services. So if you hear Dez Holmes, who runs Research in Practice, talk about contextual safeguarding, she talks really powerfully about a young woman that said to her at 18, 'The services go away, but the abusers don't', because children's services ended at 18 at that point in time. So we really need to think about vulnerable people generally.

So, you know, some of our children might not disclose that they've been exploited until they're young adults, until they're vulnerable adults. We need to make sure that that's open to them.

Q. But this whole area of exploitation in a community setting extends to children in care when they're in the

community, albeit they're in residential care. It's got to, surely, because --

A. Yeah.

Q. And I think, historically, it would appear that periods when they were away from their care setting, it was almost like it was out of sight, out of mind, and perhaps if there was any concern about risk, it was risk within the family setting, not risk within the wider community.

Of course, you'll be aware that we did hear evidence in this case study from, I think it was 'Murphy', about the exploitation that occurred to him when he was in care and how he got drawn into a group who abused him and other young people, a group of older men in the Edinburgh area. So this is --

LADY SMITH: Also, very significantly for him, at the age he is now, he could track a change in himself, and it wasn't a change for the better, after the way he was treated by those men.

A. Yeah, and that's why it's got to be a wider response than just people that work in children's services. You know, in other areas I've worked, people like transport police are really crucial in this, because they see -- well, they will regularly see children and young people at train stations at night or at bus stations at night,

and knowing -- understanding that that might mean that they're vulnerable and being exploited, they then would refer that.

You know, hoteliers are often significant in this, because they will tell you what they see going on in their hotel rooms.

So that whole system is really important because they will spot the change as well.

MR PEOPLES: So just before we perhaps break, can I just put it this way: that the issue of exploitation, as you've described, is an issue which is now, we can be reassured, is at least getting the attention it ought to have received some years ago, and, indeed, the records show that that was an issue that ought to have been addressed, but didn't seem to really get the attention it should have done, but things are changing.

A. Absolutely.

Q. Including within Edinburgh.

A. Yes.

Q. And more nationally in Scotland.

A. Yeah. Oh, absolutely. Yeah.

MR PEOPLES: Well, that's probably a good point. I've got very little more to go, but I think --

LADY SMITH: I think we should give you a breather, Amanda. Just a short one. All right.

(3.01 pm)

(A short break)

(3.11 pm)

LADY SMITH: Welcome back, Amanda. Are you ready for us to carry on?

A. I am.

LADY SMITH: Thank you.

Mr Peoples.

MR PEOPLES: My Lady.

Amanda, I am reaching towards the end of your statement. What I would like to do is leave your conclusion until the end, because I think it contains things that you probably want to say at the end --

A. Yeah.

Q. -- and anything else you want to add.

But before I do that, I'd just like to have your thoughts on some things that were raised by the Gordon Collins significant case review. I'm not going to take you to the detail, but I may refer you to one thing that's said. But can I put it this way -- and we have them here. I'll give the references. This is not for your benefit; it's just in case we do talk about them.

The significant case review was in two parts in 2016 and 2017; part 1 in 2016 was EDI-000000754, and part 2

in April of 2017 was EDI-000000749.

So I may at least give some references, if necessary, to the areas that I'm going to ask you about or ask you to comment on.

The review questioned, firstly, how well the then current policies, procedures and guidance, both local and national, supported safe caring and the disclosure by children or staff of concerns.

Secondly, it also questioned the extent to which external scrutiny, including that of independent inspectorates, arrangements for the oversight of complaints by external managers and others, and the use of external confidantes, I think also known as trusted persons, had fulfilled the expectations of the inquiry teams that had recommended their introduction, because the SCR concluded that children rarely disclose sexual abuse by carers and residential care staff rarely disclose concerns about the behaviour of colleagues. They said it's this silence that enables abuse to continue for so long, and that's at EDI-000000749 at page 5.

So I think they were trying to see whether there should be a discussion about whether these well-intentioned changes were really producing the desired effect, if one reason for them was to try and

encourage more disclosure so as to effectively put an end to the silence, either of children or staff.

One gets the sense from the McKinnon review that that is still something that can be questioned. Do you agree?

A. I think it's back to the point I made earlier, that nobody in my position is ever going to say everything's okay. You know, you -- it is difficult for children to disclose. It's difficult for staff to whistleblow. It's difficult for staff to raise concerns. It happens. It does happen. But I think it is -- we've talked a lot today about different lines of sight and different lenses into practice and into a child's world. It's making sure you have as many of those as possible that make it more possible for children to disclose, and when they do disclose, that you give them all the support that they need at that point which they've disclosed. Because that's the other thing that we know from the file review, is children have said things and not been heard, not been listened to, not been supported, and then have never said things again.

Q. But it's maybe also -- all these different ways of trying to see what's happening, they don't necessarily involve an explicit disclosure, but what you're saying is that when you do all of these things and you see all

of these things in records and what children are saying, it may be they'll not explicitly say something, but you must be able to see them, understand them, analyse them and act on them because, if they don't speak directly, they're speaking indirectly?

A. Absolutely.

Q. Is that -- because explicit disclosures to persons in authority by children and, indeed, by staff, it would appear, are not an easy thing?

A. No, they're not, and that is -- you know, again, we've talked a lot about understanding children, knowing children, knowing what their behaviour is like, understanding that if they change the way that they are, then that's saying something and prompts that professional curiosity that we've talked about. You know, some children don't disclose until they're adults. Some children never disclose what's happened to them, but we strongly suspect things have happened to them in their lives, either within their family or outwith their family.

So it is about having lots of safe places where children can talk if and when they want to talk, but also having people around them that care for them and understand that the way that they're behaving is also them talking to us.

Q. You've already suggested things that might be considered, like LADO, the Care Inspectorate's approach to inspection and methodology, and so obviously these are things that you would like to see debated and discussed and perhaps lead to some changes in the current system.

But the significant case review, I think, made an important observation, that the impact of changes, including changes in implementation of inquiry recommendations, had not been evaluated to determine which of the changes had produced what they described as 'a tangible and beneficial impact as regards the safety of children while in care'. That's at page 80 of EDI-000000749.

What they went on to say at page 84, I think it was, was while a considerable amount was known about what does not work for children and the indicators of poor quality care, less was known about what measures have been successful in reducing abuse in residential and other care.

It went on to say too little attention has been paid nationally and locally to how well new developments or services are improving outcomes for children. There was a need for evaluation, focusing on impact on the child's experience.

Now, has the position changed or can that still be said today?

A. I think it has changed. So we don't do serious case reviews anymore, we do learning reviews. So the way that we do them is --

LADY SMITH: Sorry, do what reviews?

A. We do learning reviews now.

LADY SMITH: Learning reviews.

A. So the methodology of doing them is different.

Families are much more involved in those reviews and have a much stronger voice as part of that review, as do children and young people. They're independently done. They then report into the Child Protection Committee, which is independently chaired. So there's more kind of rigour in that, and the focus is on learning much more and on changing practice going forward.

Social work I don't think historically has had a very strong connection to its evidence base. So we're different to our health colleagues in that, and that is changing. You know, you do see practitioners now that are doing PhDs, that are doing research. You see joint posts with universities, which is becoming more common. You know, organisations like Research in Practice; those kinds of organisations are about bringing practice and an evidence base together.

So I think we're in a better place than we were when I qualified nearly 30 years ago, but there's always more that we can do in that space.

MR PEOPLES: The only reason I'm pointing this up is about them questioning the systems and all the changes, important as they may have been, particularly since 2000, as they recognised there had been changes, is that they still were questioning this in 2017 and 2016, and that's not that long ago, that really people weren't really -- they were doing things, but not necessarily evaluating whether they were making a real difference to the child in care.

A. And that's --

Q. And the safety of the child in care.

A. And that's why the voice of children is really important and that independent advocacy. You know, I would say the role of reviewing officers being independent is really, really important, and, you know, external advocacy involved in that system is really important. And having those different eyes into: so what -- so what's it like to be this child in this place today and how do we know, is the question we should constantly ask ourselves.

Q. Just while I'm still on this, if I may ask, to assist the understanding of those who seek to take effective

action to protect children in care from abuse, the significant case review ended their phase 2 with two sections headed 'Dilemmas and inconsistencies' and 'Focus for change'. Perhaps I can just read what was said there.

Under 'Dilemmas and inconsistencies' -- and this is at EDI-000000749, page 87 -- it says this -- and they've looked extensively at the facts of the Gordon Collins situation, as well as the background of the literature, practice, policies and so forth, and they say this:

'At the end of the day, this case, as others in the review and inquiry literature, has many dilemmas and inconsistencies that need to be properly understood before effective action can be taken.'

Then they list a number of bullet points, the first being:

'The behaviours we identify in this report that were helpful for the girls (listening and empathy, concern for the young person and spending time with them) are all skills that Gordon Collins had and are the same skills he used to groom them.'

So there we have an appropriate relationship-building approach which is risky and has turned into a grooming tool in his case.

Now, Collins seemed to be able to convince those

that worked with him that he was doing all the right things.

A. Yeah, and there will always be people that abuse children, you know, and there will always be people that will seek roles in positions of trust because they want to abuse children.

Q. But --

A. It's our job to make it less likely and put more systems and processes in that make it less likely. But there is a balance. You know, the thing -- the big message that children tell us is that they want to feel loved and safe and happy, and we have to hear that. We have to find a way of making that as safe as it can be.

Q. I don't think they were suggesting that that wasn't a proper approach. I think the message was: well, it might seem that someone does all the right things, using all the right approaches, but think the unthinkable; they could be abusing a child.

A. Absolutely.

Q. And that's what Collins did.

A. Absolutely.

Q. And got away with it for a long time.

A. Absolutely.

Q. And then they also said this:

'Good staff working relationships and a shared staff

ethos promotes consistency and security for children ...'

Which in one sense is a good thing, but it says:

'... but may also lead to insularity and a "groupthink" that makes it difficult for staff to recognise warning signs amongst colleagues.'

I think you would agree that that's the danger; that there are benefits of good staff working relationships and shared ethos, but the ethos has got to be right, and --

A. I'm not sure I do agree with that, to the same extent.

Q. Do you not?

A. Because I think -- it's the word 'insularity' that I find concerning about that.

Q. It says 'may lead'; it doesn't say 'will lead'.

A. But if you're working -- you can have a really tight staff team, you can have a really good children's house, where the team have worked together for a long time and they work really well, but if you're working in a learning organisation, it doesn't lead to insularity, because they're constantly looking out at where practice is better. I would expect them to be looking at research, looking at evidence, on training courses, meeting other people, going to other authorities to look at their practice, going to other places to look at

their practice.

So, yes, it may lead to insularity, but if you've got a learning organisation with systems around it, it wouldn't do.

Q. Okay.

LADY SMITH: What I hear from you, Amanda, is taking me back to you promoting curiosity.

A. Absolutely.

LADY SMITH: A desire to learn what's going on outside your organisation.

A. Yeah.

LADY SMITH: Am I right? It's not enough just to have good working relationships within the organisation so the children aren't sensing any tension amongst staff and there's reliability amongst staff. That's not enough, and it has its risks.

A. Absolutely, yeah.

MR PEOPLES: Then they also said this -- and I think this was just a warning to say: think about these things --

A. Yeah.

Q. -- don't think that because certain things are in place, the chances are that the system is relatively safe.

But they also said this:

'Strong controls protect children - from themselves and each other but risk physical abuse and perhaps

sexual abuse. Child led and educative approaches can address underlying problems and build resilience but may be inadequate when dealing with children in crisis or if units are understaffed.'

So you don't have any real quarrel with that, do you?

A. I think what sits beneath that is some of the debate we were having before about: is restraint something that happens or is it something that happens in extremely rare circumstances? Because I read that 'Strong controls protect children' as in a climate in which you can restrain to protect children. I don't think we would be operating in that way now.

Q. I think to try and -- I mean, obviously you haven't read the whole report, or I haven't, but I think to some extent saying that perhaps to have clear boundaries and things of that nature -- maybe 'controls' is the wrong choice of word.

A. It's how the boundaries are enforced that I think is significant there.

Q. Yes.

A. You know, it's back to Maslow's stuff again. Children need to understand the world in which they live, and they need to understand rules, and we need to help children become adults in which they can understand

rules and manage within rules. But it's how we do that. It's how that control happens.

Q. It also says this:

'Small units and good staffing allow for better staff/resident relationships but also enable more one to one activities where opportunities for abuse might occur.'

Now, I suppose the message coming across is that a number of these features, which to an extent are seen as beneficial features, carry with them a risk, and you've always got to be alive to the possibility that they're being misused.

A. Absolutely. Absolutely, which is why we only bring children into care where we absolutely have to bring children into care, and we do absolutely everything we can to be the best corporate parents that we can be to those children.

Children should be with their families wherever that's possible, because there are inherent risks in children not being.

Q. And yet you probably can't create a risk-free environment in residential care, and indeed you probably wouldn't want to, because it wouldn't be good for the overall development of the child.

A. You can't. You know, childhood isn't risk free.

Q. Yes.

Now, it also says this:

'Strong leadership gives staff and children confidence and stability and provides a clear ethos, but the ethos may be wrong, and strong leadership can be difficult to challenge when there are concerns.'

Now, I think we've heard some evidence suggesting that might have been the situation at times at St Katharine's. So do you take on board that point?

A. Yeah. I mean, again, I think I'd -- I don't think 'strong' is necessarily the right word. You know, I think -- I wouldn't say that strong leadership is leadership where you can't be challenged. You're not being -- you're being a dictatorial leader if you can't be challenged; you're not being a strong leader.

You know, social work and social care is -- we've talked about it a lot -- is evolving and is often a source of debate. You know, I would expect people to tell me that I'm not right. I'd expect people to challenge me. I'd expect people to say, 'I don't agree with you, 'cause that's how we learn, isn't it? So I wouldn't consider it being a strong leader if people couldn't challenge you.

Q. Yes, but you might get someone who is not strong in a physical sense, but simply is quite dominant in their

views and carries a certain authority that they may think is healthy and is the right form of authority and the right approach, but that has its dangers, because staff either may decide not to challenge it because they're afraid of the consequences or they're in a subordinate position and so forth. I think that's just the message. It's not trying to say that you don't need someone that has a clear view of how to lead a team. I think it's just trying to say you have to be careful not to simply see someone who runs things in a clear way is necessarily doing it the right way.

A. I think that's absolutely right, but I think that's a kind of slightly outmoded view of what strong leadership looks like, and this idea that there's a kind of hero leader.

Q. So what's strong leadership in your estimation?

A. I think it's about being part of a team. I think it's about having a really clear vision of where you need to go. And I think I've got a really clear vision of what good corporate parenting looks like and some really strong expectation about that, but I wouldn't prescribe the journey we take to get there. I'd have a clear set of outcomes and say: this is what good looks like, but I think there's a debate about how we do that, and I don't think it's about one person; I think it's about

a team.

You know, I'm part of a big team, 11 and half thousand people, that deliver children's services, justice and education across the city, and everybody in that team has a leadership role in leading the bit of the service that they're involved in. So I don't think it is a one-person thing, and I think that kind of implies that you have a charismatic leader that does this. I think if you've got that kind of charismatic leader who is in charge, then that's maybe a signal that you need to worry about. It should be a team and other people should be part of this as well.

Q. Yes, and I think, in fact, if one reads the whole report, it would also say that Gordon Collins, although he wasn't the leader, was a charismatic person --

A. Absolutely.

Q. -- within St Katharine's and was popular with both staff and young people.

A. Absolutely.

Q. Yet he used that to exploit and groom and abuse, ultimately, a number of girls, both there and at -- well, a number of girls; one at St Katharine's and I think three others at Northfield Young People's Unit.

A. Yeah.

Q. Now, it also says -- and I think you'll probably agree

with this proposition or comment -- that:

'Investigations are necessary if offenders are to be brought to justice. However, if investigations are prolonged or superficial and fail to provide sufficient evidence to prosecute or do not result in protective action (whether or not there is a criminal charge), undertaking investigations can do more harm than good.'

Now, do you agree with that?

A. Again, I think it's interesting language, because it sort of implies that therefore you maybe shouldn't undertake investigations, and I don't agree with that. I think you should. I think they should be timely. They should have support wrapped around them. And I think we do have to be really mindful of potentially retraumatising people as they're involved in those investigations. But that doesn't mean we don't do the investigation.

Q. I'm not sure, in fairness to them, they're probably going that far, but I think they are just sounding a cautionary note that: don't embark on an investigation or don't have a complaints process where it takes too long that either you put them off or the outcome is such that they're not going to do it again because they think it's pointless.

A. I would agree with the too long, but there's almost an

implication there that unless you're sure that you can take action to get rid of somebody or there'll be a prosecution at the end of it, then don't investigate, and I don't agree with that. I think we should investigate. Even if that investigation goes nowhere, we've absolutely got to investigate.

Q. Now, interestingly, as you see, the next thing they say is, 'We make no recommendations'. Now, that's unusual for a review.

A. Yeah.

Q. As we discovered, the action plan wasn't the review's work; it was Heather Smith's.

But they do say this, and maybe this is something that you would echo:

'We have already noted in the report that implementing the recommendations of the Edinburgh Inquiry and other reviews became an end in itself without reflection on the overall quality of care or outcomes for children. We have also noted that following inquiry and other reports, a number of procedures have been introduced, each good in themselves, but adding to a child protection and criminal justice system that does not always safeguard children or meet their needs.'

So that's quite wise advice, isn't it? Because

you're telling us that, basically, this is a never-ending process.

A. Yeah.

Q. It's got to just continue and continue and continue. Don't focus on a plan.

A. Yeah, and I think it's -- you know, that's the thing that I mentioned before about you doing it because Ofsted is coming, rather than you doing it because it's the right thing for the child, you know. So it can become -- improvement can become a kind of industry in itself, and it shouldn't be. It should -- and it shouldn't be seen as a criticism of practice either. It should be seen as something that we just do. You know, we're constantly trying to make what we do better. We're constantly learning. So we will always be trying to improve. We'll always be trying to evolve. So it should be our day-to-day business.

It's that curiosity thing again. It should be what we do as part of -- you know, we're in a very privileged position. We're involved in lots of people's intimate personal lives. We should be trying to do the absolute best we can do when we're doing that, and that has to be about questioning ourselves all the time. Are we as good as we can be? And if we're not, what can we do to make it better?

Q. But you have to have the requisite reflection on whether what you're doing will improve things and also, having done them, whether they have improved things.
A. Absolutely. Absolutely.
Q. I suppose just to end this bit, would you agree that perhaps two of the biggest and most difficult challenges are, firstly, ensuring that those who work with children are suitable and, secondly, achieving culture change?
A. Yeah.
Q. Because as the SCR succinctly put it -- and this is at page 55 of EDI-000000754 -- culture is often stronger than the measures put in place to change it.
A. Absolutely.
Q. I think you've probably seen a flavour of that?
A. Yeah.
Q. It's hard to shift culture.
A. It's really hard to shift culture.
Q. Now, that's all I'm planning to do with the case review, and I think it is a document worth reading. You would agree?
A. Absolutely.
Q. Can I go back to your statement.

You say at 167 that personally you feel:

'... sickened by the duration and extent of abuse which has occurred on [City of Edinburgh Council]'s

watch. It is made worse by the fact that [City of Edinburgh Council] failed to take appropriate or effective action to prevent further abuse from happening.

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

Now, that's quite a big commitment.

A. It's why I come to work.

Q. Yes. I'm just saying, you posed the 64 million dollar question at the beginning and, of course, we don't know yet where this all ends or whether we'll get the sort of changes and the culture shift that you're wanting. It's not happened yet exclusively.

A. It's getting there.

Q. It's getting there. Okay.

A. Yeah.

Q. So we perhaps need to monitor how matters are getting on, and no doubt you'll keep us in touch on that.

A. Yeah, absolutely. I mean, I think, you know, I have got a really good team. I have got lots of people who are working really, really hard, and I would want to thank them for the work that they're doing, 'cause it's difficult. This kind of work is hard. Making these changes is hard, you know, and they are working incredibly hard in difficult circumstances and are

making it better for children and young people. You know, there are tangible -- there's tangible evidence that it is better. It is not perfect by a long stretch of the imagination.

I really want to thank the young people who've spoken out as part of this Inquiry, because I think we need to hear their stories, because unless we hear their stories, it won't get better.

And I'd like to apologise for -- to all the children that were in our care, that were abused in our care.

Q. And were let down.

A. Absolutely.

Q. Well, Amanda, these are all my questions.

If you wish to say anything else, you're free to do so, but I think we've covered all the areas that I would wish to cover and I think you've said what you would like to say today as well, I hope.

A. I have.

Q. I thank you for your patience with me. There's been a lot to cover and it's been a long day, and it maybe wasn't the away day you were expecting, but perhaps it does cover some of the same ground, I hope.

A. It does.

MR PEOPLES: So I wish you well and thank you very much.

A. Thank you very much.

LADY SMITH: Amanda, let me add my thanks. It's been extraordinarily valuable to hear from you again. As I said at the beginning, I'm conscious that we have delved into your expertise already once in this Inquiry, but it's certainly added to my learning to hear from you again. I'm really grateful to you for that.

A. Thank you.

LADY SMITH: Is there anything else you wanted to add before you go?

A. No.

LADY SMITH: Well, please feel free to go. Don't forget to take your own laptop with you.

(The witness withdrew)

MR PEOPLES: My Lady, I wonder if I could be excused and let Ms Forbes take over.

LADY SMITH: Thank you, Mr Peoples. (Pause)

Ms Forbes.

'Callum' (read)

MS FORBES: Good afternoon, my Lady.

So the first read-in, my Lady, is an applicant who is anonymous and is known as 'Callum'. The reference for 'Callum's' statement is WIT.001.002.2764.

My Lady, 'Callum' was born in 1965, and he tells us about his life before care at paragraphs 2 and 3. He was born in Edinburgh and lived with his mum, his dad,

two sisters and a brother in the Gilmerton area.

His dad worked in the coal mines but liked to drink. He spent his wages on alcohol and there was nothing in the house and money was very tight.

'Callum' says life at home as a child was okay, but hard, but he felt loved by his family.

He was struggling at school, though, and played truant and ultimately stopped going. He says he's dyslexic and the school assumed he was stupid. He says his dad decided it would be better him being sent away to care and to a place that would give him an education.

He talks about then going to Balgowan, and he tells us about that between paragraphs 4 and 31, and also talks about abuse there later at paragraphs 53 and 55. But all that evidence was read in, my Lady, on 15 February 2024, which was Day 418 of the Inquiry.

LADY SMITH: Thank you.

MS FORBES: But, in summary, there was bullying by older boys, emotional and physical abuse, physical punishment with a cane resulting in scars, and sexual abuse by nighttime staff members and what he calls 'special people' who would come to Balgowan and take him away and sexually abuse him in cars and houses in Dundee. He's one of the people, my Lady, who talks about going to fancy houses in Dundee and being given alcohol, drugs

and being sexually abused by adult males at these houses.

'Callum' said he would run away and often tried to get back to Edinburgh, and got himself into some dangerous situations in doing so. He would steal things.

He also talks about his time at Balgowan, saying he wet the bed and there were physical assaults by staff as a result and bullying by older boys.

He tells us he went to Wellington Farm for between six and nine months and he says there was no abuse there. He says he was moved to an assessment centre because an assessment was required in a closed centre. That's when he tells us about Howdenhall. It's in the middle of his statement, and this is from paragraph 34.

But I think, my Lady, from his records, we know that he was admitted there on [redacted] 1979. He was aged 14, and that was after running away. The reference in his records says that he was admitted to the regional assessment centre, Howdenhall, and then he was transferred to St Katharine's on [redacted] 1979, where he stayed until [redacted] 1980 and was discharged home, so he was there a number of months.

He then tells us about his time at the assessment centre in Howdenhall, it is headed as, but I think we

know from the records it's both places.

My Lady, he talks about sleeping in a dormitory -- this is at paragraph 36 -- and the fact that his mum's house was very close, only a ten-minute walk, and he could run home in three minutes.

He tells us about the staff there at paragraph 37. There was a Mr EWA or EWA, a LAM who was [redacted], and they were both team leaders. He talks about a Mr Russell, who was the head teacher at Howdenhall and was in overall charge, and he remembers SNR as being Mr PAQ.

He says at paragraph 38:

'The atmosphere at Howdenhall was ok and we could have a laugh as long EWA and LAM were not around, it was very different when they were. EWA was a bully. He'd chose what we could watch on the TV and steal fags off the boys. He shouldn't have been working with children and he'd been in trouble in the past.'

He tells us then about routine. He talks at paragraph 40 about Mr Motherwell being the one who would let him out of the bedroom in the morning to use the bathroom or to shower, and he says in paragraph 40:

'He wanted to be sure I didn't break a window and try to run away on his watch. One time, me and [he

names another boy] took his master keys off and tied him up so we could escape. He'd put his keys down on the bench when we were playing badminton and we took the opportunity. He was just a young, normal guy and aged about twenty-three years old. As a result of tying up Mr Motherwell I got six of the belt from Mr Russell and sent to the dormitory.'

He says then:

'The food wasn't great. If you didn't finish the food on your plate, they'd give you more of the food that you didn't want ...'

He talks about there being a tuck shop, but you weren't allowed to use it if you didn't eat the meals.

He says they didn't wear a uniform, but he tells us that they wore particular clothes: jeans, sweatshirts and black plimsolls.

In paragraph 46, he says:

'I spent one Christmas locked up in solitary confinement when I was just fourteen. My mum never said anything about me being locked up and I don't know if she complained to Howdenhall about it. We were given a goody bag at Christmas and I got a St Christopher medallion for round my neck, as well as some fruit and sweeties. All the boys got the same medallion. I refused to wear mine as it was so big.'

He talks about some chores, like cleaning the tables after meals, the dorms, sweeping up and keeping the place clean, and he said there was a sweetshop, but you'd have to have money from your family to buy sweets.

At paragraph 48, he says:

'The school wasn't good, but there was no caning. I got slapped by EWA [redacted] or the teachers for being cheeky. We did metal work, maths, English. I couldn't get the words on paper. If we misbehaved they gave us the belt, but there was no cane. Howdenhall wasn't quite as big on education as Balgowan was, it was more relaxed.'

He talks at paragraph 49 about getting shingles and being kept away from Howdenhall for three weeks so he couldn't give it to other residents, and he saw that as a bonus, that he wasn't allowed back for that period.

He says he never saw his social worker and she never came to check on him.

Paragraph 52, he says:

'I ran away a lot at Howdenhall. I would smash windows to get out and I was put in solitary confinement as a result. I ran away overnight and two policemen got me the next morning. I slept rough for a while when I was thirteen and slept under the bridge. I broke into shops and started drinking spirits like vodka at the age

of 14.'

He then talks about the abuse at Balgowan and, again, my Lady, that has been read in.

If we can go to paragraph 56, this is where he tells us about abuse at Howdenhall. He says:

'EWA used to take me to his house in Lasswade. He used to put music on and he gave me alcohol and made me drink it. I hated him. He was a pure monster. He was sick and he caused me physical pain. He used to catch me when I ran away from the assessment centre and take me to his house. He took me to his house on more than one occasion. It would be just me and him inside the house. He had a wife, but he'd tell her to go out and take the dogs for a walk. She was [redacted] at Howdenhall.

'The two men, EWA and LAM, were the main abusers, and the abuse was of a sexual nature. EWA had master keys for the assessment centre. I'd try to keep my head down so he didn't notice me, but if he did I'd be taken into his office. He would lock me in his office and do things to me then. I don't know if he abused girls, but I know he abused other boys as other laddies in the centre mentioned him.

'Because I was running away, I was put in a cell in solitary confinement for three months. I smashed

windows to run away and I was costing them money. I was in a senior cell for three months. I had no visitors in that time. I was just in the one room. It had a plastic window and a bed with a thin mattress. I was wearing just my underpants so I wouldn't try to run away. I got just one hour's exercise time each evening. There was another boy [he names him] ... he was put in the womble cell.

'It was Christmas time when I was in solitary confinement. The other boys were getting to go home on Christmas leave, except for me [and he names another boy] ... and he kept running away too. Then the team leaders said one of us could go home and they tossed a coin to decide which one. It was [the other boy] who won the coin toss and I had to go into a cell so I couldn't go home. I got a Christmas dinner in my cell. My mum never asked why I was in solitary confinement, she never said anything about it or complained about it.

'EWA had a big bunch of keys that he kept on a large metal ring. He used to smash the keys and the ring against my hand. I'd just have to look at him the wrong way and that was enough for him. He'd call me to his office. He tried to touch me, I started to push him away. I was 15 by then and getting bigger and stronger

and I told him I'd hurt him back.

'[redacted] was the same, always trying to touch me and watching me in the shower and he was masturbating. At 15 I stood up to [redacted] and the abuse stopped, it was the same with [redacted] but he was harder to deal with. I'd go for a shower and he'd be creeping about the showers and he'd try to do things when I was in the shower. He got me on more than one occasion in the showers on my own.'

He then goes on, my Lady, to tell us that he suffered sexual abuse from a neighbour for years until he was 15 as well, and that started after he was placed in Balgowan. When he would run away and go home, the neighbour would take him in, and that neighbour would also come into his parents' house and abuse him.

When he was 15, he says he was allowed to become a day boy at the assessment centre and sleep in his own home and he was then a day boy for six months. At 16, he left the care system.

He then talks about life after being in care between paragraph 72 and 76. He stayed with his mum and his dad for six months. In that time, he had six court appearances. He says he was always fighting with the police and getting into trouble.

He then met his wife and, at the time of this

statement, they'd been together 36 years. They got married at 17, got a flat together, had two children, a son and a daughter, and both of them have children of their own.

'Callum' tells us he's drank a lot over the years, used alcohol to block things out, and it took him years to tell his wife what happened. He's not worked for more than a couple of weeks at a time and didn't learn skills for life whilst in care. He didn't have much by the way of social skills and doesn't know how to mingle with other people, lacks trust in others and imagines that people have an ulterior motive.

He tells us about impact from paragraphs 77 to 84. He says he has nightmares about what happened in care. He was terrified of something similar happening to his own children when they were growing up.

He was a glue sniffer, which he learned in Balgowan, and was still sniffing glue when he met his wife. He's taken a lot of drugs over the years and nearly lost his leg twice. He's tried to take his life on numerous occasions.

But at the time of this statement, 'Callum' tells us he was clean for two years from hard drugs, but he is bipolar, has been given anti-psychotic medication and he's been in prison, but only on remand and for

non-payment of fines. He's never received a sentence. He has some mental health problems and paranoia.

He goes on to tell us about lessons to be learned but, my Lady, some of that has been read in before.

At paragraph 89, he makes the usual declaration, and he has signed his statement and it is dated 26 November 2018.

LADY SMITH: Thank you.

Do you have another short one?

MS FORBES: I do have another short one, my Lady.

LADY SMITH: Let's just do that.

'Kenneth' (read)

MS FORBES: My Lady, the next statement is from an applicant who's anonymous and is known as 'Kenneth', and the reference is WIT.001.002.2786.

'Kenneth' was born in 1966 and tells us about his life before going into care from paragraph 2 onwards. He says he was born in Edinburgh and stayed with his parents and his siblings, two brothers and a sister. They lived in Broxburn until he was 6 or 7, and he tells us about going to Broxburn Primary School.

His parents then divorced. He moved with his mum and his siblings to Moredun in Edinburgh and then onto Gracemount, before he went into care.

He says his life at home was like any family. They

had their ups and downs. He had a good relationship with his siblings and friends in the scheme, and he thought he had a good relationship with his mum.

He says he was moved primary school because he was having problems at school. That was partly to do with the people he was hanging about with, but says he had a mind of his own. He started skipping school when he was 12, and he had just got into first year at secondary school when he was introduced to the Social Work Department and the Children's Panel system.

He had to go to a young person's unit with his mum every week. That went on for about a year, trying to get to the bottom of why he was skipping school.

He says then his mum had a relationship which broke down and she blamed him for it, him and his siblings.

He then said he started to get into bother, skipping school. He was reported to the police for minor offences, and he says his mum made threats to leave them. He didn't take her seriously, but one day he saw her walking down the path with his sister and a suitcase, and he woke his brothers, packed a bag and told them they had to get out, as he knew social workers would be coming.

He took his brothers and they went to a workman's hut between two golf courses at Braid Hills and stayed

there for about two or three days, and then they were caught by the police, taken to the police station and taken to a children's home.

Then he tells us about the dates he thinks he was in various places. I think we know from his records, my Lady, he was in Howdenhall regional assessment centre on three separate occasions. From the records, the first time is [redacted] 1981 to [redacted] 1981, so just over four months; the second was [redacted] 1981 to [redacted] 1982; and then the third time was [redacted] 1983 until [redacted] 1983.

He then tells us about the children's home, which was where he went first, and he went there on [redacted] 1980, from his records. [redacted] taken to Howdenhall, and that's when he was admitted for the first time in [redacted] 1981.

He tells us about Howdenhall from paragraph 23 onwards. Again, he talks about the doors being locked behind you, and he says that he was put in a cell with no mattress and there was a toilet made of metal. They threw his bedding in and locked him in all night, and the next morning he was taken for breakfast.

He talks about a Mr [redacted] and a Mr [redacted] being

[redacted], and also Mr [redacted], who he called [redacted].

He says there were young children there, about 6 or 7, and children were in there for all sorts of reasons, like skipping school or getting in trouble with the police.

He says he tried to settle into a routine, but he kept getting moved in between the various places. He tells us about going from the children's home, I think, to Millpark, Abercree, Canaan Lodge, and in between he was back and forward to Howdenhall.

He tells us about the routine.

At paragraph 20, he says the food was okay. It was basic.

There was something called the classroom; however, he says he wouldn't call what they did there schoolwork. It was below his level and he did colouring in. That was the first occasion. He says he doesn't remember things being that way during his later times at Howdenhall.

They would get pocket money if they behaved and weekend leave, but it was just a day leave, not the whole weekend.

He says there was a sort of uniform that they wore, which was jeans and whatever they supplied.

He says at paragraph 33 his mother said she didn't want him back, and the only thing he wanted was for her to sign the form to allow him to smoke.

He talks about contact with his brothers, and he says he was never encouraged to have contact with them and, whenever he asked about them, the social workers would go and find out and come back and tell him. But he did get to see them after a while, and he kept in touch with them as best he could, he says, throughout care.

He says, though, that one of his brothers ended up being adopted and taken to Hong Kong, and he found that very difficult, to say goodbye, because he didn't know if he would see him again. He says he didn't see him again until he, 'Kenneth', was about 19 or 20 and he knocked on his door. He says that that brother is happily married and has great children.

He goes on to talk more about Howdenhall and says about a big blue bus that would take them on trips. There were camps at Loch Doune and Pease Bay. He says they went to camp the second time he was there. They did fishing, hillwalking and he spent the summer there one year, and that was fantastic. At that time, he was there for about five weeks.

Christmas was quiet because some of the children

went home.

He tells us at paragraph 41:

'I did try to run away from Howdenhall, but sometimes I was just late back. If you did try to run away, you would get locked in a cell. Sometimes, you could be in there for the whole weekend. The cell was designed so that you couldn't hurt yourself.'

He then tells us about abuse at paragraph 42:

'One of the boys, [he names him], his younger brother made an allegation against a member of staff, EWA. I believe now that it was an allegation of sexual abuse. I remember [the boy] sitting in the communal room, pulling his hair out.

'There was a sexual allegation about EWA at Pease Bay. EWA wasn't there after that. He had been in charge of the smallest boys' room. I was in the middle, then the older room. EWA had been at Dr Guthrie's. He was in his fifties by then. I just tried to stay away from him, all the boys knew to stay away from him.

'There was an incident I had with EWA, it was possibly during my second time there. It wasn't sexual in nature, it was probably a physical assault but I can't remember the details. I didn't see any sexual abuse at Howdenhall, but it sticks in my memory about

[the boy] pulling his hair out.'

He tells us about his time in Millpark. He was admitted there on [redacted] 1981, from paragraph 45. From there, he went back to Howdenhall.

My Lady, we know from his records that he went back to Howdenhall because he absconded from Millpark in [redacted] 1981, and he ended up being picked up by the police. He was readmitted on [redacted] 1981.

He then tells us about going to Abercree, and that's from paragraph 55. He went there from [redacted] 1982 and was discharged in [redacted] 1983. Secondary Institutions - to be published la

Secondary Institutions - to be published later

He then tells us about Canaan Lodge, and he was admitted there on [redacted] 1983. He was there until he went back to Howdenhall in [redacted] 1983. Secondary Institutions - to be

Secondary Institutions - to be published later and that's how he ended up back in the assessment centre for the last month of his time in care.

I think we know from his records that his supervision was terminated, ultimately, on [redacted] 1983, and he left from Howdenhall.

He tells us about life after being in care from

paragraph 78. He wanted out of care and complained about being in care. He managed to get a B&B from an emergency panel.

He says that life after care was a rocky road. He got mixed up with the wrong people, mixed up with drugs. He met his partner and realised that she was a more important thing to have in his life. They met when he was 18. He says he was a father by 21.

He tells us about working in the building trade on a garage forecourt and did agency work, and then he got a full-time job through agency contacts and was in the building trade for 12 years.

He says they had their second child when he was 25. They lived in the same house in Edinburgh for 25 years, but in that area there were problems with drugs, so they decided to move away from Edinburgh. But he kept working, he says, as an HGV driver.

He tells us about impact from paragraph 86, and says he feels his experiences in care had an effect on his education.

At paragraph 89, he says he's found it difficult to form relationships and to trust people, and it's affected his relationship with his kids.

In relation to hopes for the Inquiry, at paragraph 90 he says:

'People are blind to what they don't want to see. I hope there will be an acknowledgement of what happened, an understanding of what went on, to find out how it was ever allowed to happen, to examine the failings of the system and what should have been done differently. I should have been monitored more closely in care. There should have been more effort made to find the right place for me. Life could have been so different.'

'Kenneth' has made the usual declaration. He signed his statement dated 23 November 2018.

LADY SMITH: Thank you very much.

I think we'll stop there for today, because I know that the one outstanding read-in is quite a long one, but I feel we should be able to fit it in on Friday. Although we're hearing the final submissions for this chapter, there should still be enough capacity within the day to cover that then.

Meanwhile, three names: EWA [redacted], LAM [redacted] and Mr PAQ [redacted]. These are men who are not to be identified as referred to in our evidence outside this room because they have the protection of my general restriction order.

Otherwise, thank you all very much, and I'll rise now until 10.00 on Friday. Thank you.

(4.03 pm)

(The Inquiry adjourned until 10.00 am on Friday, 31 January 2025)

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