Scottish Child Abuse Inquiry

Witness Statement of

Pauline McKINNON

Support person present: No

1. My name is Pauline McKinnon. That is the name I was known by professionally. McKinnon is my maiden name. My married name is Isles. My date of birth is [redacted] 1963. My contact details are known to the Inquiry.

Background / Qualifications / Training

2. I studied for my social work degree from approximately 1994 to 1997. In 1998, I started work at City of Edinburgh Council as a locum social worker. Then, in 1999, I got a job in the Community Care Resource Team which dealt with substance misuse. I worked in that team for around six years. I then got the job of Planning Commissioning Officer, for substance misuse, criminal justice and sex work, in the Health and Social Care Department. Latterly, in the five years before I retired, I started work as a Quality Assurance Officer (QAO) in the Quality Governance and Regulation Service.

Experiences at City of Edinburgh Council

My role

3. There were four of us in the Quality Assurance team, but we were a sub-team of a larger team which took in regulation work and lead officers for adult protection, child protection and domestic abuse. The quality assurance sub-team worked under two

senior managers. My direct line manager was Keith Dyer and the senior manager above him was Jon Ferrer. Jon has since left the council, but Keith is still the manager of that team.

4. The Quality, Governance and Regulation Service is part of Children's Services but has done work for other council departments, as required. The main aim of the quality assurance team, is to identify issues in services provision, assist teams/individuals to improve practice and to monitor and review improvement activity.

5. To undertake the quality assurance work, we were required to do the National Health Service (NHS) Quality Academy. That involved completing a course through NHS Lothian. An element of my job when I worked as Planning & Commissioning Officer in Health and Social Care, was to deliver training in both substance misuse and suicide prevention. During this time, I also completed my post-graduate diploma in Public Sector Management.

Safecall

6. Safecall, in its broadest terms, is employed by the council to receive whistleblowing complaints directly, without having to go through any council managers, so that you can make complaints anonymously. It is based in Newcastle.

7. In the instance of the Edinburgh Secure Services (ESS) whistleblowing complaint, I understand the whistleblowing report went to the chief social worker, who, at that time, was Jacqui Irvine. It went to her in the first instance and then, the council asked Safecall to manage it on their behalf. That's what I believe happened. The Safecall employee I dealt with, while making my investigations, was Dennis Shotton. I think he was an ex-police officer and in addition to working for Safecall, he also worked as a part-time magistrate.

8. As far as I know, whistleblowing complaints go to Safecall for them to look at the best way of managing the complaint. The council's legal services would have had oversight of Safecall's processes. The monitoring officer and chief solicitor was Nick Smith.

When I became involved in the ESS report, I had Dennis Shotton as my main contact within Safecall and two council contacts, who were both members of legal services, Laura Callender and Chris Peggie. Tim Smith was the director of Safecall, but I had no dealings with him.

9. I assumed that, once a whistleblowing complaint went to Safecall, they would then be in charge of that investigation and would deal with the complaint on a neutral basis. My experience during my investigation for the ESS report was very different. That is all I can tell you about Safecall. I had no dealings with them prior to the ESS report and I don't know any more about how they operated.

My appointment as Investigation Officer

10. I would say, at the start, I was duped into taking on the role of Investigating Officer (IO). My line manager, Keith Dyer, told me that a whistleblowing complaint had been received. He told me that Safecall were looking for someone to go through the Swift Client Database to get some general information about the eleven cases referred to in the complaint and that this was a piece of work he wanted me to take on.

11. There were a number of meetings organised between myself and Dennis Shotton and also with Laura Callender and Chris Peggie from legal services. This was all happening during COVID, so we had our meetings on Microsoft Teams. The whistleblowing complaint was received on 15th September 2020 and then, on 15th October 2020, I had my initial Teams meeting with Dennis Shotton. During that meeting, Dennis stated that Safecall had been very clear with the council about what they required. They were looking for an IO, and I was it. The terms of reference were laid out in that meeting and they are contained within the report.

12. Dennis explained that my role was to look at the allegations made in the whistleblowing report and look for any evidence around those cases, or any other cases where power and control were used inappropriately by staff at ESS. The information and resources I was expected to interrogate are contained within the report.

13. Dennis made it very clear that I would be taken out of the quality assurance team. I would be working basically for Safecall and I was to use Laura Callender and Chris Peggie as my council contacts. I wasn't to discuss my investigation with anyone else and I was to have no contact with my manager or my team in the council.

14. I had some previous experience of investigations. I had participated in investigations for Michelle Miller, a previous Chief Social Work Officer. An example of this was a similar investigation to that of ESS into NHS and social work practice at a step-down facility for older adults. I didn't think, at the time I was appointed IO, 'I can't do this'. I knew I was capable of doing it, but it wasn't necessarily what had originally been asked of me by my line manager. I thought it was one thing, but it turned out to be another.

15. At the time I was appointed IO, the council didn't have an investigating team. They now have a full investigating team. This came about following the Tanner Inquiry and report.

The process of my investigation

16. I was provided with the whistleblowing complaint and obviously, I had no idea who submitted that. From the complaint, I knew about the original eleven cases. That was it. That was all the information I was given about the nature of the complaint. I was just told to go and interrogate whatever resources I could find and speak to appropriate people. I'm a very resourceful person and because I had worked in the council for such a long time, I knew who I should be speaking to and what I should be looking at.

17. As part of my investigation I wanted to speak to the people who were the subject of the allegations in the whistleblowing complaint. Dennis Shotton said that this would form part of a follow-up investigation. I don't know if that happened.

18. Right from the off, there was evasion from the managers I attempted to speak to. I contacted the manager of ESS, Peter McCloskey, and the senior manager for looked after and accommodated children, Scott Dunbar. I needed to know about the policies

and procedures that ESS were operating under because, as well as the overarching council policies and procedures, ESS had their own. I emailed to get that information and I would either just get very blank responses, 'I don't have this', or 'It would take us too long to look for that information'. It was all this 'toing and froing' by email. The only thing that Peter McCloskey sent me was the staffing structure which is included as an appendix in the report. I realised I wasn't going to get anywhere with that so, I just had to look at council policies and procedures.

19. At that point, in parallel with my investigation, I became aware of the Police Scotland investigation. During my interrogation of information, the number of cases rose from the original eleven in the whistleblowing complaint to thirty. I had found disturbing information pertaining to a further nineteen young people and I was really concerned at what I was finding.

20. In January 2021, I submitted an initial findings report to Dennis Shotton, Nick Smith, Jacqui Irvine and a senior children's and family services manager, Bernadette Oxley. I think it was at this point that ESS managers and staff were suspended. I also believe that Scott Dunbar, the senior manager for looked after and accommodated children, was suspended. There was a series of suspensions.

21. After my initial findings report was submitted, I was looking into any resources I could find as I realised that the malpractice in ESS actually went beyond the initial whistleblowing complaint. In March 2021, due to the evasion and lack of cooperation from managers, I asked to have sixty-four boxes of archive material delivered to me. The material contained further information about the disturbing things I had been uncovering.

22. I spent around a month, in a room at Waverley Court, going through it all, trying to piece together the cases. The documents were very chaotically filled. There were incident records, or 'pink forms' as they were called, which staff were obviously filling out and passing to managers, only for them to be immediately sent to archive. Nothing that came up on those incident records ever appeared to me to have been actioned or taken forward. There was also a disconnect regarding the cause and effect of

incidents. For example, I found pink forms and other information which showed that young people were penalised during and after incidents by being locked up and isolated for lengthy periods, or their room was stripped and precious items deliberately removed.

23. Complaints handling was a major area of concern for me. Some complaints were taking an inordinate amount of time to be resolved, some between one hundred and three hundred days. Effective resolution either did not happen, or the response was inadequate. In some cases, submitting the complaint and the inadequate response further traumatised young people, or they withdrew the complaint when they realised that nothing would come of it. Complaints investigations would be undertaken by ESS managers who did not carry out thorough investigations and did not question the issues raised. There appeared to be management collusion in the deliberate ignoring/delaying of resolutions, for example, investigation reports would sit with Scott Dunbar without sign-off for lengthy periods.

24. In terms of the Quality, Governance and Regulation Service, the senior manager, Jon Ferrer, was in charge of the complaints service. It became clear to me that there was a lack of professional assertiveness on his part about ensuring that those complaints were resolved timeously, appropriately, and that any issues arising from the complaints were investigated fully. All he was ever doing was just sending very sweet emails saying things like 'Scott, do you think you could get round to signing this off'. The whole response was inappropriate, totally unprofessional, chaotic and collusive.

25. In my personal opinion, Children's Services managers, including those working at ESS, were very much aware of what was going on at ESS. The Tanner Inquiry uncovered deficiencies in the overall management of Children's Services and there was a feeling that the Director, Alastair Gaw, along with, Andy Jeffries, Sean Bell and Scott Dunbar were sitting on a number of issues that they hoped would never see the light of day. Alastair Gaw and Andy Jeffries were allowed to retire at the commencement of the Tanner Inquiry and, unfortunately, both Sean Bell and Scott Dunbar have since suicided.

26. One of the projects with which I was involved before the ESS investigation was People's Stories. I was involved in its development and co-ordination. We would contact social workers and ask if they had any service users who wanted to take part. We would meet with them, talk to them about the level of service they received and where they thought there should be improvements. We would tape record the meetings.

27. Criminal justice really embraced the project, but children and families didn't want to know, so my manager and I went to see Sean Bell. I really wanted to get into, what are now called, the children's houses to speak to children who were being looked after and accommodated. As soon as we mentioned going into children's houses, Sean, who was always a larger than life, jokey character, turned on the head of a pin. He looked directly at Keith and said, "*That is a piss poor idea and it ain't fucking happening*". Keith, rather than being professionally assertive and telling Sean that it would be happening, just went 'Okay'. That was it and the project died a death at that point. I think Sean was worried about what we might find out if we went in.

28. My prior dealings with Sean Bell of course influenced my later thoughts as I was uncovering all of this chaotic information in the course of my investigation. There was stuff written in black and white in complaints and incident records that stated very clearly that there was a problem. There was an investigating officer report which stated *'I have found this an extremely difficult complaint to follow up because the atmosphere in the place is toxic. There is toxicity in the staff group and toxicity in the care of the kids*', or words to that effect. That report would have been submitted and signed off by Scott Dunbar. The manager of ESS should have seen that report and it should have been discussed within the management team, but it was never followed up. That is only one instance of many things that I read that should have been ringing alarm bells.

Supervision / Support while carrying out the ESS Investigation

29. As a social worker, you receive regular supervision on a fortnightly or monthly basis. I wasn't receiving anything like that while carrying out my investigations and I was uncovering some quite traumatic information. Not only was I not receiving support or

supervision, I had no assistance actually carrying out the investigation itself. The only person that I did speak to was Heather Smith who was in my quality assurance team. The reason I spoke to her was, I had to look at what was happening with the Gordon Collins Significant Case Review Action Plan.

30. Following Gordon Collins imprisonment, there was a significant case review. My colleague, Heather Smith, was asked to follow up the case review and develop an action plan to carry the recommendations forward. I didn't know much about it, so I had to speak to Heather to find out what had been happening with the action plan. I thought the action plan was probably being implemented and should be addressing some of the issues I was finding in the ESS investigation. When I actually started interrogating the Action Plan, I found that it had stagnated and nothing appeared to be happening, despite councilors being assured by the Chief Social Work Officer, Jacqui Irvine, that it was being implemented. It was not and it appeared to me that council officials were being misled. Euan Currie, Lead Officer, Adult Protection, took at face value what he was being told by Scott Dunbar without any material evidence or review and this mis-information was communicated to Jacqui Irvine.

31. Heather experienced a disturbing lack of action by senior managers when she tried to highlight cases of concern to Andy Jeffries, Sean Bell and Scott Dunbar. She attended a meeting with them which also included the Quality, Governance and Regulation Managers, Jon Ferrer and Keith Dyer. It became apparent to Heather that no investigation of her concerns was carried out and there was no follow up from either Jon Ferrer or Keith Dyer. The cases she highlighted were included in the ESS report some years later.

Dennis Shotton's role in the investigation

32. Dennis, who was employed by Safecall, was appointed by them as Independent Investigating Officer in the ESS investigation. I believed that Dennis's role was to coordinate the investigation, to work alongside me and to be my support. In the cover letter, that went to the council with the ESS report, it states that Dennis Shotton and I

were in constant contact and were having regular meetings. I would say that this was the case at the beginning, but contact and meetings tailed off once I was immersed in the investigation. I was left to get on with it.

33. Initially, after my appointment as IO, Denis and I had monthly meetings, during which, we set out the terms of reference and I set up a work plan. Once I was into the meat of the investigation, the meetings tailed off and I was working in complete isolation. I really didn't have any relationship with Dennis at all. I was getting on with the job and I think I was only expected to contact Dennis if I had a problem, or I needed to discuss something specific with him. Perhaps, had it not been for COVID-19, Dennis would have been more present to oversee the investigation.

Liaising with Police Scotland

34. During my investigation into ESS, Bernadette Oxley, who was at that time senior manager, came to me and told me that the police had started looking into the cases in the whistleblowing report, to see if there had been any criminal activity. I was to be the conduit, together with council employee, Douglas Stephen, who dealt with the General Data Protection Regulation (GDPR). I was to deal directly with Police Scotland or go through my colleague, in terms of information dissemination to the police.

35. The police investigation didn't stop me doing my investigation, although there was a lot of information to gather together for them. I'm a very organised, practical person, so I just made sure I set time aside to find the information for Police Scotland. There were times when the information Police Scotland requested, was very useful for the report.

36. I was never asked to provide a statement to the police. In terms of disciplinary action taken against ESS employees, Carey Fuller, the investigation officer for the Criminal Justice Service, dealt with that. I also provided Carey with information which I collated as part on my investigation, but I had no part in the disciplinary side of things.

Prior investigations into Edinburgh Secure Services

37. There was an incident which I think was very pertinent to my investigation and is very pertinent to the Inquiry. Approximately five or six years before the ESS whistleblowing complaint, a Children's and Family Planning Commissioning Officer, Kirsten Adamson, was asked to carry out a review of the St Katharine's Service, which was part of Edinburgh Secure Services. The outcome of her investigation mirrored what I then found five or six years later in the ESS report. She drew her findings to senior managers' attention and advised them that there were issues concerning the quality of care at St Katharine's and probably more widely in ESS. The senior managers were the same then as they were during my investigation and would have been Peter McCloskey and Scott Dunbar.

38. I was working in planning commissioning at that time, probably around 2012, and knew nothing about ESS. I remember Kirsten coming to see me to ask me to look after a hard copy of her report. She told me that she had submitted an electronic copy of her report and her concerns to senior managers, but it had disappeared off the system. It had been deleted. Kirsten and I were both Planning Commissioning Officers and I think she knew she could trust me.

39. I didn't read the hard copy of the report that Kirsten gave me. When she was leaving the council, she took the report back. I remembered Kirsten's report when I was carrying out my own investigation, so I contacted Peter McCloskey and Scott Dunbar and asked for a copy of the St Katharine's report. They came back to me and said they had never heard of it and didn't know anything about it.

40. It appeared that there was evasion around the St Katharine's report. During the ESS investigation I contacted Kirsten directly. Kirsten was working away from home at that time, but she was able to send me a photograph of each individual page of her report. I'm afraid I no longer have those photographs, but as I said, a lot of what she found, five or six years earlier, mirrored my ESS findings.

41. That incident really sticks in my head because the St Katharine's report was just brushed under the carpet and people claimed not to know anything about it. Managers knew, years before, what was going on in St Katharine's and ESS and did nothing. I highlighted it as a missed opportunity in the ESS report.

42. There was another missed opportunity to address the issues at ESS which is discussed in detail in the ESS report. The previous Chief Social Work Officer, Michelle Miller, had been concerned at reports from the Young People's Service about possible abuse of young people at ESS and promised an immediate root and branch review of the service. I think it was at this point that she left and, yet again, nothing was done.

43. There is a restricted folder on the council system, in my name, in which everything pertaining to the ESS investigation was filed. Because the subject matter is child protection, and because it was a major investigation, it should all still be there and none of it should have been deleted. All emails and all electronic resources, including the St Katharine's report, should be in there in properly named folders. Should the Inquiry wish to see that information, Keith Dyer is in a position to access it.

Challenges I faced during my investigation

44. During the ESS investigation, the isolation, lack of support and lack of trust I had in those who were supposed to be supporting me, did impact my mental health. The investigation itself subsumed my whole life. I was thinking about it constantly and it did take over my life for the eight or nine months I was working on it.

45. It appeared to me that Dennis Shotton was not happy that I had looked at the Gordon Collins Action Plan. It was at this point that I began to feel that I was very exposed and did not have the protection that I was promised. I believed the Gordon Collins Action Plan was relevant to my investigation as it dealt with similar issues. The lead officer for adult protection, Euan Currie, was supposed to be coordinating the action plan and making sure that it was being implemented. I asked him to provide evidence showing that the action plan was being achieved. He said there was no material evidence, Scott

Dunbar had just told him that it was all in hand. So basically, they were being told something that was just smoke and mirrors. I wrote to Dennis Shotton, Jacqui Irvine and Bernadette Oxley stating that I had serious concerns and I provided comments/questions about each of the individual actions. I said that the Action Plan was not being implemented appropriately and that, based on what I was finding at ESS, abuse of young people had continued. I said that the Gordon Collins Action Plan required an immediate root and branch review.

46. A couple of days after I had written expressing my concerns, I received an invitation to a meeting with Dennis Shotton and Chris Peggie. This was on 12th February 2021. It was a Friday morning and I went to the meeting thinking it was just going to be a catch-up meeting. Dennis started off the meeting by aggressively saying, in a raised voice, "*What do you think you were doing looking at that action plan*?". I was completely caught off-guard.

47. I explained my reasons for looking at the action plan and carried on being berated by Dennis while Chris sat there with a very serious face. I asked who exactly was annoyed that I had considered the action plan and whether it was Nick Smith, the monitoring officer and chief solicitor. I asked because I had always had a very good relationship with Nick. He was always very friendly towards me and took me seriously as a professional person. He was always very interested in my views on things. At this point, Chris Peggie said to me and I'll never forget it, "*Well, it's not as if he's going to come round to your house and bash your head in with a baseball bat*.". Dennis Shotton just sat there and said nothing to challenge that comment.

48. The inference I took from the comment made by Chris Peggie, was that Nick was angry, just not angry enough to assault me. I was absolutely taken aback that someone would say such a thing in a professional meeting. After the comment, I told Dennis and Chris that they had assured me, at the outset of this process, that I would be protected and I didn't feel protected. I then discontinued the meeting. I really should have made a complaint about the comment, but at that point, I was just so caught up in what I was doing.

49. I realised then that I couldn't trust anyone in the process and Safecall was not a neutral party in the relationship. It seemed to me that Safecall were at the behest of the council and were doing the council's bidding. Dennis Shotton should have been supporting me in looking at the Gordon Collins Action Plan but instead, what he was saying was 'you need to stop doing this'.

50. I knew I needed to do something about what had happened in the meeting on 12th February and that's when I wrote the email dated 15th February 2021, outlining my concern and upset, to Dennis Shotton and copied in Chris Peggie and Laura Callender. I also addressed what I believed to be backpedalling from them as they had stated in that meeting that this was a review of ESS, rather than an investigation. I believe their thought process was that I was digging too deep and uncovering too much and it was becoming a bit of a scandal. I think they wanted to cut it dead now and I was told by Dennis, at the meeting on 12th February, that I had four weeks to pull my report together. In my view, they just wanted it written so they could brush it under the carpet. I didn't feel that there was any commitment to those children or young people or to uncovering the truth.

51. I received a two or three line response, to my email of 15th February, from Dennis Shotton basically saying I had misconstrued what was said at the meeting on 12th February. I don't feel I misconstrued anything. I think the nature of my email made senior managers panic. They knew I wasn't a 'yes' person and they knew I wouldn't let it lie. Dennis Shotton and I did have a further meeting, at which he was back to being jovial. I reported on progress to date and neither, the meeting with Chris Peggie, nor my email, were discussed again, but the four-week deadline was rescinded.

52. I was a social worker, supposed to be looking after and doing my best for vulnerable members of society. I was also a quality assurance officer, so I was supposed to be rooting out poor practice and abuse. That's why I had to write the email of 15th February 2021. I was basically saying, 'I'm not going to be quiet about this'.

53. Following my concerns, the Gordon Collins Action Plan underwent a major review, instructed by the Chief Social Work Officer, Jacqui Irvine, and the recommendations were then subsumed into the ESS Improvement Plan.

54. I thought, when I began the ESS investigation, that I was actually going to be doing something good and I was going to improve the lives of young people in the care of ESS. In contrast, I was left feeling like I was the enemy. I was digging stuff up that people didn't want me digging up. I was drawing attention to things that senior managers didn't want me drawing attention to. I did feel that I could be 'thrown under the bus' at any moment. I felt as though I was in a really precarious position. I felt that when I submitted the ESS report, the council would try to say that I had misrepresent the evidence and there would be some sort of payback. That didn't quite happen, but I was waiting for it.

55. After I completed the ESS report and went back to my team, there was a protracted period of contact by Jacqui Irvine, Nick Smith and a consultant working in Children's Services, when I would be asked for information which was readily available in the report. It appeared to me that nobody had actually read it. All I was doing in response to their questions was referring them to specific pages, within the report, for the answers. I wondered why I had been asked to carry out an investigation as I didn't feel that anyone was interested in the result. Once again, it made me question people's commitment to actually addressing these issues.

56. It was around the time that I went back to my team that Scott Dunbar suicided. I remember having a supervision session with my manager, Keith Dyer. During the session, Keith asked me "*How are you feeling about Scott's suicide, because after all, you wrote the report*.". I was still feeling very raw and I felt that he was saying that I was responsible for Scott Dunbar's suicide. I felt like the investigation and report, and ultimately me, were being blamed and that I was the enemy.

Edinburgh Secure Services Improvement Plan

57. It was agreed, following the review of the Gordon Collins Action Plan, that the recommendations from that would be added to the ESS Improvement Plan. That resulted in over one hundred new actions which would have been significantly less, had the original action plan been implemented.

58. An industry grew up around the development of the ESS Improvement Plan. It took the form of a spreadsheet with a traffic light system to highlight areas achieved and those which remained outstanding. The pulling together of the spreadsheet was an industry in itself and went on for months. There was a senior management group that pulled together the recommendations, with a Quality Assurance Officer who was meant to be driving it forward. That particular Quality Assurance officer just ended up being an admin worker for that group. There was no professional assertiveness there to hold managers to account and get things moving forward. Also, they combined recommendations which I feared would dilute them or allow them to be forgotten about.

59. The industry was all around the development of the spreadsheet, not the actual implementation of the actions. It made it look as though something was happening. It was the usual, they talked about it a lot, but nothing was actually done.

60. When Scott Dunbar suicided, they promoted another senior manager who came from the Youth Offending Service, Steve Hart. He is now in the role of senior manager for, what was then referred to as, looked after and accommodated children. Steve Hart appointed Alan McDonald to a temporary post, working under him. Alan McDonald was one of the managers, in my report, who turned a blind eye to complaints and to what was going on within ESS. I wrote a very strongly worded email to Steve Hart advising him that I believed this was a very poor appointment because of the issues I had uncovered concerning his involvement in the collusive management style. Nothing came of the concerns I raised and Alan McDonald is now in that role, working with Steve Hart, and other senior managers.

61. There was such prevarication around the ESS Improvement Plan and I queried whether the people in charge of implementing the improvement plan actually had the ability to do it. At the point of my retirement, some three years after I submitted the ESS report, nothing was happening with the ESS Improvement Plan. I do feel very strongly that the Chief Social Work Officer, Rose Howley, along with, Steve Harte and Keith Dyer should be interviewed regarding progress of the ESS Improvement Plan and asked to provide material evidence of its effective implementation.

Culture within City of Edinburgh Council

62. I moved to Children's Services from Health and Social Care as I desperately needed a change after 13 years in the same job. Going to the Quality, Governance and Regulation Service was the worst mistake I could have made. The good people in the team left due to the inept, chaotic management style, bullying by one particular individual and Keith Dyer's inability to manage the attitude of, and bullying by, that individual. The goalposts could be moved at any time and I personally was 'thrown under the bus' by Keith Dyer on more than one occasion, due to his inability to understand the role of the team and what it should be achieving. He was completely out of his depth and the culture in the team became very toxic.

63. Before the Tanner Inquiry, Children's Services operated a toxic, patriarchal management system and people were wary of Andy Jeffries and Sean Bell, including Jon Ferrer and Keith Dyer. If the Quality Assurance service was operating as it should have been, and was being effectively managed, issues such as those perpetrated at ESS would have been identified much sooner. The team was not performing optimally at the point of my retirement due to inept management and the deficient, risky practice caused by one Quality Assurance Officer who lacked a social work qualification and the lack of relevant skills and experience of another. In order to comment on social work practice, Quality Assurance Officers should be qualified social workers who have the necessary experience, skills and abilities that the job requires. They should be professionally assertive and able to identify issues with practice and act accordingly.

At the point of my retirement the Quality Assurance team, including its management, was not fit for purpose.

64. More widely, there was a generally toxic environment of collusion, chaos and incompetence which was in direct conflict with my professional standards and personal values. I was always a square peg in a round hole in the council. In every job I've had at the council, I've always been used as a workhorse by managers and I've ended up doing a lot of their work. Then, when I did the ESS investigation and report, it really highlighted to me just how toxic the council actually is.

65. Any attempts to address poor practice were challenged. I would say there was an institutional culture of marginalising and victimising the person doing the challenging. Even though you were trying to live up to your professional standards as a social worker, and also your moral compass to improve things for people in vulnerable positions, it felt like there was always someone there chucking an obstacle in your way. It was as though people were quite happy with the chaos because that way, they didn't have to face up to anything or address anything.

66. After the ESS report was submitted, Bernadette Oxley left and the council brought in a new Director and a new Chief Social Work Officer who both came up from York. The chaos and incompetence just seemed to increase at that point. Other people might have a totally different opinion about working with the council, but that was my experience.

67. Ultimately, I do believe that senior managers, ESS managers and the staff group were aware of what was going on at ESS. I do believe that there was bullying, cover-up and collusion. One case from the ESS report which has stayed with me was a young man who attended a Children's Hearing with one side of his face swollen and bruised. This had allegedly been caused by staff banging is head off a bench. His mother demanded answers. The Young People's Service did try to investigate but it went nowhere. I question how this could have been allowed to happen.

68. After sifting through all of the information, including complaints, incident records and staff notes, I have no doubt that the issues within ESS were known about. The fact is, there were a number of missed opportunities which could have saved young people from going through the emotional, mental and physical trauma they experienced at ESS. I just cannot understand why nothing was done about ESS earlier. Those in senior positions just closed their eyes to the problem and left it for somebody else to deal with. I didn't feel that children, who were looked after in Edinburgh, were safe, nurtured or protected and I still felt like that at the time of my retirement.

Leaving City of Edinburgh Council

69. I retired from City of Edinburgh Council in May 2024. The motivation was that I just could no longer work for Children's Services and, in particular, the Quality Assurance team. Management from both my line manager and the Chief Social Work Officer was inept and I continued to feel that I did not fit. My value base and moral compass were continually challenged and the toxic atmosphere in the team, including bullying by a colleague, drove me out. I felt that I wasn't being allowed to do what I came into social work to do, which was to help vulnerable people. I wasn't really ready to retire when I did, but I felt that, had I stayed, I would be lying to myself.

Helping the Inquiry

70. My overriding wish, is that something comes out of this, not for me, but for the young people who went through what they did. I feel there has been a huge injustice there and I hope for all of those young people, most of whom will be adults now, that there is some sense that justice has been served.

71. My fervent hope is that City of Edinburgh Council will learn lessons from the findings of this Inquiry. The council's Children's Services is currently undergoing a major review and restructure. I hope that the findings of the Inquiry will positively inform and influence the future work of that department to prevent incidences of abuse and

mismanagement. I hope that children and young people who are looked after by City of Edinburgh Council will be safe, nurtured and protected and that there will be some form of justice for those who were not so fortunate whilst in the council's care.

Other information

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

Signed..... Signed by: [redacted] 4766788C70E946B... .....

Dated..... 28 November 2024 .....