Friday, 14 February 2025

(10.00 am)

LADY SMITH: Good morning. I hesitate to say this, but today, all being well, is the last day of hearings in relation to Phase 8, and we move on to the stage at which we are now going to hear the final block of closing submissions.

I think we are due to begin with City of Edinburgh Council, Mr MacAulay, is that right?

MR MACAULAY: Indeed so, Mr Batchelor appears.

LADY SMITH: Yes, thank you very much.

Mr Batchelor, when you are ready.

Closing submissions by Mr Batchelor on behalf of the City of Edinburgh Council

MR BATCHELOR: Thank you, my Lady.

On behalf of the Edinburgh City Council, I adopt the written submissions which have been lodged with the Inquiry. I also adopt what I said before in closing remarks at the close of Chapter 12.

I don't intend to repeat everything that's in the submissions document, but there are some points which I do consider bear repeating and some other points which I would wish to highlight.

The City of Edinburgh Council establishments under consideration in this chapter, my Lady, were Wellington,

St Katharine's and Howdenhall. One overarching theme which arose in relation to those establishments was the contrast between care and control. The evidence indicates that for too long children in secure care in List D schools were regarded as needing to be controlled rather than being vulnerable children in need of care.

LADY SMITH: Yes, and the problem with that -- one of many problems with that, of course -- is it means the mindset of the staff is: these are little human beings who need to be controlled.

MR BATCHELOR: Indeed, and that theme runs throughout all of the further themes, I think, really, or certainly most of them, which I will go on to highlight in my submissions, it plays in to everything.

LADY SMITH: Yes. Would you agree the mindset rather should be along the lines of: these are children who need to be understood and cared for appropriately?

MR BATCHELOR: Indeed, my Lady, a child-centred approach.

LADY SMITH: Yes, thank you.

MR BATCHELOR: The City of Edinburgh Council acknowledges there was widespread abuse of children in their care at the establishments I have mentioned. Children suffered physical, sexual and emotional abuse. The evidence suggests that some abuse, particularly abuse in the form of excessive restraint and abusive isolation practices,

continued until as recently as 2019, and it is a matter of significant concern to the council that such practices have been found to have been taking place so recently.

The council acknowledges there were also widespread failures in historic systems for safeguarding children, as well as significant failures by the council in its response to allegations of abuse and in the process of implementing changes as a result of investigations into abuse.

There is also a concerning pattern from the 1990s onwards of a failure to learn lessons from previous inquiries and investigations, and, in particular, until recently there has been a cycle of abuse, inquiry and attempted but limited change.

That such abuse was occurring and went unchecked over such a long period is appalling, and as they did at beginning of this case study, my Lady, the City of Edinburgh Council wishes to apologise to each and every child who suffered abuse whilst in their care.

The council provided a response to the very detailed framework document provided by the Inquiry prior to the commencement of this case study. Subject to some minor points of detail, the council does not dispute the findings narrated in the framework document and findings

in fact can be made based upon the conclusions reached in that document.

The Inquiry also has the benefit of a detailed statement from Amanda Hatton, Executive Director for Children, Education and Justice Services, which was provided to the Inquiry and the benefit of Ms Hatton's evidence, which I hope was of some use to the Inquiry.

LADY SMITH: Yes.

MR BATCHELOR: Turning to the applicant evidence, my Lady. The council does not seek to challenge the evidence of applicants regarding their experiences at Wellington, St Katharine's or Howdenhall. A significant number of applicants provided evidence in relation to the way things were in the days when Howdenhall operated as an assessment centre, particularly in the 1970s and 1980s. The picture there is of a prison-type environment where the emphasis was on control and where children were routinely physically and emotionally abused.

Physical abuse involved assaults on children but also disproportionate physical chastisement. There was also a pattern of allegations of physical and sexual abuse perpetrated by a particular individual, Mr EWA, often referred to as EWA. It appears that had Mr EWA still been alive when the police investigated

him, numerous charges would have been brought against him.

One notable feature, my Lady, is that although Howdenhall was an assessment centre, it operated under locked conditions. Applicants' descriptions of the establishment and the regime there are redolent of a prison environment. Applicants spoke to being strip searched and being covered in powder to treat lice. There were communal facilities and dormitories with little to no privacy. Isolation or solitary confinement appears to have been used routinely and potentially as an automatic punishment for running away.

LADY SMITH: Just picking up on the descriptions of being covered with powder to treat lice, I suppose there is absolutely nothing wrong, indeed there is everything right, about treating a child who was suffering from lice, but I had the impression it was the way it was done and how the children felt about the way it was done that was the problem, nobody was explaining properly and sensitively what was going on.

MR BATCHELOR: Indeed, my Lady. It conjures up images of the Shawshank Redemption, or a film of that nature --

LADY SMITH: Yes.

MR BATCHELOR: -- where prisoners were being brought in and stripped naked and covered in powder, rather than

an environment where children are being cared for.

LADY SMITH: Yes, and indeed, the impression I had was that there would be no effort to identify which children were suffering from lice and which weren't, they would just all get done, that's what everybody had.

MR BATCHELOR: It seems to have been that sort of automatic application.

LADY SMITH: Thank you.

MR BATCHELOR: Little, if any, consideration appears to have been given to the suitability of Howdenhall as a placement for any child, and it appears that most children from the Lothians were taken into care there. Some applicants reported being admitted there in the early hours of the morning, which may suggest there were a high number of emergency admissions. There also appears to have been a huge mix of children with different needs. I think this is a point which has been highlighted by INCAS in particular.

For many this would have been their first experience of care, and the environment was anything but child-centred, as we have discussed, and I can imagine it would have been extremely frightening.

Some children were kept at Howdenhall for an excessive period of time. In particular, we heard evidence from Killian Steele, who was there for a period

of around 11 months. That is clearly an excessive period for an assessment to be carried out. The impression is that Howdenhall was used really as a holding station for children whilst the local authority worked out where to send them next, but little consideration was given to the suitability of Howdenhall for any of those children.

Although fewer applicants gave evidence of their experiences at St Katharine's and Howdenhall after 1994, the Inquiry does have the benefit of very detailed reports from Kirsten Adamson, Stella Perrott and Pauline McKinnon and the council accepts the terms of those reports. In my submission, each of them is a comprehensive and diligent piece of work and the conclusions are convincing. The council submits the Inquiry can have confidence in making findings of fact based upon those reports.

The evidential picture in relation to Wellington was more mixed, with applicants having different experiences. One applicant who was there in the 1960s considered that it compared favourably to other placements he had had. However, one other, who was also there in the 1960s, reported that every day he was either punched, shouted at, kicked or touched up by staff.

Applicants who were there in the 1970s reported broadly favourable experiences, however, one applicant, GLV, who was at Wellington in the early 1990s, reported being heavily restrained and suffering injuries as a result.

We also heard evidence from staff in relation to Wellington, and in particular oral evidence was heard from two individuals who gave evidence of their experiences as outsiders coming into Wellington in the late 1980s/early 1990s. In my submission, overall there was evidence that would support a finding that practices at Wellington, at least at times, were not dissimilar to those at the other City of Edinburgh Council establishments being considered, where we have the more detailed reports available.

LADY SMITH: Mm-hm.

MR BATCHELOR: Evidence in relation to St Katharine's and Howdenhall was also provided by a number of staff witnesses, and as we discussed at the close of Chapter 12, broadly speaking those individuals fell into two separate camps. The council are not going to seek to resolve the disputes between individuals about specific incidents in this case study, however, in my submission, there are certain areas where the weight of evidence is such that the Inquiry can draw reliable

conclusions.

There are also some aspects of the evidence which was given by all of the witnesses which supports the conclusions drawn by Pauline McKinnon in her very detailed report.

LADY SMITH: Mm-hm. Of course, one of the very significant features of Pauline McKinnon's report was the extent to which she identified systemic failings, not just individual instances --

MR BATCHELOR: Indeed.

LADY SMITH: -- but a whole series of systemic failings, which hadn't been picked up by the Care Inspectorate either.

MR BATCHELOR: Indeed, my Lady. I have briefly mentioned the external inspection in the closing submission in passing and that may be something which the Inquiry will wish to consider.

LADY SMITH: Indeed. I wonder whether, Mr Batchelor, something that flags up is that no organisation such as the council should approach matters on the basis, 'Everything must be fine because the outside inspection hasn't picked up a problem'.

MR BATCHELOR: Indeed so.

LADY SMITH: In fairness to the inspection system, it may be the way it's set up, and it's limited in what it can do

is the reason why it is not picking up problems. But it is for the organisation itself to be vigilant.

MR BATCHELOR: Indeed, and I think that that is what Amanda Hatton said in her evidence, that what you need to have is different lines of sight into practice.

LADY SMITH: Yes.

MR BATCHELOR: To allow you to identify problems, because you cannot rely upon any particular one line of sight.

LADY SMITH: No.

MR BATCHELOR: Moving now, my Lady, to some of the key themes which have arisen through the evidence.

Many of these have already been discussed in the framework document highlighted in submissions by Counsel to the Inquiry and INCAS. It is worth saying something, however, about some of the key themes which arose specifically in relation to Chapter 12.

First, the issue of restraint, my Lady, has been, I think, a recurring theme throughout this case study. It is the council's position that there is clear evidence that restraint, particularly prone restraint, was being used unnecessarily and inappropriately, and there was, generally speaking, an insufficient focus on deescalation.

Having regard to the whole evidence, the Inquiry may therefore conclude that the threshold for physical

intervention at St Katharine's and Howdenhall was lower than it should have been, based on the model which was in place, the CALM model, at the time.

Prone restraint appears to have been one of the accepted techniques under the CALM model. That involved the child being held by three or more staff, often much larger than them, face down on the ground. It is clear that that risked injury to the child and could have been extremely frightening for them.

Further, there is evidence which indicates that restraints may well have been instigated by some staff goading children, and toy fighting was also a practice which we heard some evidence about and which has arisen, certainly in other chapters of the evidence that I am aware of, during this case study. That practice, although now outlawed, does seem, at least in the 1990s, to have formed part of official council policy.

The risks arising from that practice are self-evident, my Lady, indeed many of them were recognised in the council's guidance at the time, despite the practice being permitted. The Inquiry may consider there is sufficient evidence to find the practice of toy fighting provided the opportunity for situations to escalate rather than de-escalate, and also for staff with particular attitudes to reinforce the

power they held over children.

The abuse of power dynamics, my Lady, was also apparent through some of the other evidence we heard, through the removal of children's possessions or bedding from their rooms.

One inspection report from Howdenhall that we heard evidence about, my Lady, in the late 1990s indicates that there were 55 restraints in a period of approximately two months. That's quite a striking figure. In my submission it is clearly excessive and is redolent of a regime where restraint is being used as a means of control.

That figure can be contrasted, my Lady, with the figure provided by Amanda Hatton in her evidence, where, through a number of developments, including better staff training, but particularly better care planning and better understanding of children, the number of physical interventions was reduced to six across all of their houses during 2024, and none of those physical interventions involved prone restraint.

Another recurring theme, my Lady, is isolation, or, as it was referred to at Edinburgh Secure Services, single separation. There is consistent evidence throughout the period of time being considered by the Inquiry that children were shut or locked in rooms as

a means of control rather than as a means of care. That was clearly a feature of the regime at Howdenhall when it operated as an assessment centre, and a significant number of applicants all gave evidence that this happened to them, often as a punishment for running away.

However, there were much more recent examples also. Kirsten Adamson's report in 2013 provides a comprehensive overview of an incident where a child was isolated in their room for an excessive period of time for an entirely trivial reason.

The significant case review by Stella Perrott also concluded that children at St Katharine's were subjected to isolation and removal of personal possessions unnecessarily and for prolonged periods of time.

The McKinnon review also identified seven cases where there were concerns over single separation, those practices continuing into the 2010s.

Complaints and investigations was another theme which arose. In particular, there was a theme of insufficient or perfunctory investigations in relation to complaints being carried out. There was also a theme of insufficient support being provided to children, either to make complaints or after they had made disclosures.

One example of a perfunctory investigation was provided by Kirsten Adamson in her evidence. By the time she became involved in the 2013 complaint, there had seemingly been a prior investigation by an ESS manager, which had led to the complaint not being upheld. However, Kirsten Adamson gave evidence that staff had not even actually been spoken to or interviewed about the complaint, and there was no paper trail. It is clear that no proper investigation had actually been conducted prior to that complaint being rejected.

Pauline McKinnon's report also reached the conclusion that children were being discouraged from complaining.

One further aspect of this theme, my Lady, is that those who are carrying out the investigations need to feel safe and need to be appropriately supported. It is apparent from Pauline McKinnon's evidence that she did not feel safe or appropriately supported, despite being the person tasked with carrying out the whistleblowing investigation.

LADY SMITH: Yes.

MR BATCHELOR: The council accept that Pauline was not appropriately supported during her investigation. She should have been receiving regular supervision and

support from line management. It is also important that those working with potentially traumatic material have access to therapeutic support, and the council are considering how best to provide that.

LADY SMITH: Yes, and one of the problems with Pauline McKinnon's position was, not having been supported by the council during the process of doing her investigation and reporting, things got worse afterwards, it went on. No message had come from the council that this was somebody who had to be respected and treated properly, which was very disturbing to hear how things were for her afterwards and it was clearly still affecting her.

MR BATCHELOR: Yes.

Exploitation is another theme which is highlighted in the framework document, and about which we heard some evidence. The dangers of children who are in care but on home or weekend leave being exploited in the community by organised groups is something which organisations need to be aware of. We heard evidence from 'Murphy' Secondary Institutions - to be published later Secondary Institutions when he seems to have been only 14, Secondary Institutions - to be published later

The dangers of child sexual exploitation are very real in a modern day context, my Lady, as we heard from Amanda Hatton. This may be something which the Inquiry may wish to consider in more detail. [redacted]

[redacted] Amanda Hatton gave us some evidence about work being done by the council in relation to contextual safeguarding, but also gave evidence that certainly her opinion is the approach to child sexual exploitation in Scotland is not as evolved as it is in England, where there have been a number of significant police investigations and prosecutions.

It is worth saying a word about secure care in general, my Lady. I think this is perhaps another overarching theme, that when we look back on how children were placed into approved schools, List D schools and secure care, the conclusion may be drawn that a lot of them didn't need to be there.

LADY SMITH: Mm-hm.

MR BATCHELOR: A lot of these children were in need of care and protection rather than being put there because it was absolutely essential.

LADY SMITH: Yes.

MR BATCHELOR: External inspection is something which we

have already briefly discussed, my Lady. It is notable the Care Inspectorate reports for Edinburgh Secure Services did not pick up on the problems highlighted by the McKinnon report.

LADY SMITH: Yes.

MR BATCHELOR: But there is always a danger with external inspections, even unannounced inspections, that they merely obtain a snapshot of what's actually going on. It is sometimes necessary to have a much more deeper look under the bonnet. That's where the different lines of sight into practice and thorough auditing processes come in.

LADY SMITH: Yes, mm-hm.

MR BATCHELOR: One theme which arose loud and clear in relation to Edinburgh Secure Services, my Lady, was culture. As Amanda Hatton acknowledged in her witness statement and evidence, there is an inherent risk with residential care and perhaps particularly with secure care that it can become very insular and develop a closed culture. There was a striking piece of evidence, in my submission, when we heard about the exchanges between 'Dominic' and senior management at the council in the late 1990s/early 2000s, which give a flavour of a reluctance that St Katharine's and Howdenhall should be open to outside influence and

scrutiny.

There were also specific cultural issues identified by the McKinnon report within ESS. Her conclusion was the culture was not child-centric, complaints from children were discouraged and there was a macho culture in place. There was an abuse of power dynamics, which emphasised control over care. As Ms Hatton noted in her evidence, when you see a closed culture that is a red flag.

There have obviously been broader cultural issues at the council, my Lady, we have heard evidence about the Tanner report. One striking piece of evidence, I think, which perhaps sums up the distrust felt by staff and the overall cultural situation was that Kirsten Adamson asked Pauline McKinnon to safeguard a hard copy of her investigation report into St Katharine's when she went on secondment. The fact that she felt the need do that is a matter of significant concern.

LADY SMITH: Yes, and fortunately she still had it --

MR BATCHELOR: Fortunately she did still.

LADY SMITH: -- and was able to photograph it from Orkney to get it to Pauline McKinnon.

MR BATCHELOR: And it has been a valuable piece of evidence.

LADY SMITH: It has.

MR BATCHELOR: The failure to learn lessons is something

which is definitely a theme in relation to the City of Edinburgh Council establishments being considered here.

The council considers there were failures at both a local and organisational management level to ensure that recommendations for investigations and reports were incorporated into practice and were improving the standard of care to be provided. A stark example of that, my Lady, is the Adamson report in 2013.

LADY SMITH: Yes.

MR BATCHELOR: Turning finally, my Lady, to reflections on the evidence and improvements which have been made.

The Inquiry heard detailed evidence from Amanda Hatton about changes which have been made since the McKinnon report. The council have made a number of structural and governance changes since Amanda Hatton took up her position, and I know that over the last day or so a number of structure charts have been provided to the Inquiry. I understand discussions will be ongoing about that, and perhaps developing a further chart to assist the Inquiry in understanding all the interactions between the various committees and bodies that there are --

LADY SMITH: That would be very helpful.

MR BATCHELOR: -- because it is fairly complicated.

LADY SMITH: We may regret asking for that, I realise,

Mr Batchelor, but the one we have got so far --

MR BATCHELOR: Maybe on a piece of A3 not a piece of A4, my Lady.

LADY SMITH: Yes, I can understand that, but the initial one is quite light on detail. I think I need to ask for more.

MR BATCHELOR: Ms Hatton provided evidence of trying to embed a performance culture within the council, my Lady. Some examples of that are that standards have been provided for social workers, all residential staff have undergone trauma-informed training. There have been some changes to recruitment policy. There is now one manager for every residential house, rather than across two houses, and employees and children are matched through a specific process to those particular houses.

There is also now a clear escalation process in place if there is a disagreement between staff and the reviewing officers.

Another key change which will assist staff greatly is the transition of the recording system from Swift to Mosaic, that's a significant investment by the council to bring their recording systems up to date and in line with most other local authorities, but the change to that recording system should greatly help staff, as all of the child's information should be stored in one

place. It also means that there should be much more up-to-date performance information and that complaints data will be easy to access and trace.

Ms Hatton also provided evidence on the impact the Inquiry itself has had at the council, it has been a valuable if painful exercise for the council to review all the evidence of what has gone wrong in the past and have worthwhile conversations about how they can make changes for the better in the future.

Ms Hatton also gave evidence herself that she personally has found it extremely challenging at times to effect change within an organisation like the council, even as executive director she has encountered resistance. She did, however, consider that the council was making progress.

LADY SMITH: Yes.

MR BATCHELOR: My Lady has posed the question, and Ms Hatton, I think, posed the question to herself of how, given the council's troubling history, there can be any confidence that history will not repeat itself again. In my submission, the first lesson is that improving is something which should be constant. When asked by Inquiry counsel whether the council will ever get to the end of the road with the improvement plan, Ms Hatton answered that you do not ever get to the end

of the road. Every organisation should have an improvement plan. It should never be finished and you should always be striving to get even better as an organisation. You must guard against complacency at all costs.

Following the Edinburgh Inquiry in 1999, the action plan was regarded as completed and complacency set in. The focus cannot be on action plans as an end in themselves, but has to be on the child's experience and the standard of care provided to the child. It is therefore up to the council to earn the trust that this time things are different. They can do that by being a learning organisation that continuously listens to the voices of children and families and challenges itself to ask how it can be better at supporting children and young people to live their best lives.

The council hope that the evidence provided will have given some reassurance to the Inquiry, and to those for whom the council are corporate parents, that meaningful changes are being made.

LADY SMITH: Thank you very much, Mr Batchelor.

I would now like to turn to representation for His Majesty's Chief Inspector of Prisons and I see, Ms Durkin, you are here to address me on that.

Whenever you are ready, I am ready to hear you.

Closing submissions by Ms Durkin on behalf of His Majesty's Chief Inspector of Prisons

MS DURKIN: My Lady, as you know, I appear on behalf of His Majesty's Chief Inspector of Prisons.

Two items are set out at the beginning of the closing submissions to bring to my Lady's attention.

The first is the retirement of Ms Sinclair-Gieben, who was the Chief Inspector, and who gave evidence to the Inquiry.

LADY SMITH: Yes.

MS DURKIN: She has been replaced, and was only replaced on 3 February, by Ms Sara Snell. She has had an opportunity to input, but to a limited extent, to the closing submission.

LADY SMITH: Yes.

MS DURKIN: Her deputy, who had been the Acting Chief Inspector, has read the evidence of Ms Sinclair-Gieben, so there is some comments on the evidence.

LADY SMITH: Good.

I think I am right in recalling that when Ms Sinclair-Gieben had to retire last August, her deputy immediately was put in an acting position, so there has been continuity of a person and particularly a person initially who was very familiar with the job in that role right through to now, but you say now the new

inspector is in place and that's Ms Sara --
MS DURKIN: Snell, my Lady.
LADY SMITH: -- Snell, isn't it. Yes. thank you.
MS DURKIN: In addition to that, my Lady, the Children (Care and Justice) Act 2024 has --
LADY SMITH: Yes.
MS DURKIN: -- received royal assent, so from 28 August 2024, all children on remand or in receipt of custodial sentences are held in secure care accommodation and not, as had been the case, in young offenders' institutions.
LADY SMITH: Yes.
MS DURKIN: There was evidence to the Inquiry that the Chief Inspector had actively campaigned for this policy and during Ms Gieben's evidence, she restated why children in her view, and in the continuing view of the Chief Inspector, should be placed in secure care which is under social work supervision --
LADY SMITH: Yes.
MS DURKIN: -- and not in the prison estate.
So it is very much welcomed by the Chief Inspector. For completeness, my Lady, Polmont Prison Young Offenders Institution continues to accommodate males from ages 18, not children, but 18 to 21, and females are accommodated in the young offenders' institution in

Stirling. Secure care, my Lady, is a matter for the Care Inspectorate, not for the Chief Inspector.

LADY SMITH: Thank you, that update is very helpful.

There was no doubt that Ms Sinclair-Gieben was absolutely clear in her views that the prison estate was not the place that any child under 18 should be placed, for whatever reason. She gave very cogent reasons herself why that should be so. I am sure she is pleased to see what the development has been since.

MS DURKIN: I think they all are extremely pleased.

LADY SMITH: Yes, thank you.

MS DURKIN: In the closing submission there is some additional detail on the statutory authority, et cetera, I don't propose to address my Lady on that at the moment. But maybe move to contextualise the evidence again on the inspection and monitoring role that the Chief Inspector has.

LADY SMITH: Thank you.

MS DURKIN: There are 17 Scottish prison establishments and there is also two community custody units, my Lady, for females under the age of 21. There is guest inspectors, partner agencies are used for these inspections, such as Education Scotland and the Care Inspectorate, and for inspections in Polmont, one of those partner agencies that was always invited to join the Chief Inspector's

inspection would be the Children's Commissioner, because of course children had been held in Polmont Young Offenders Institution.

There are surveys and have been surveys organised prior to every inspection, and these surveys focus on physical/verbal abuse.

Focus groups are organised by the Chief Inspector with prisoners as part of the inspection.

Process, and very importantly, my Lady, there are lay volunteers who are in prisons throughout Scotland on a weekly basis, and these independent prison monitors are monitored themselves by the Chief Inspector, and that gives young people and children in the past an opportunity to speak to these independent volunteers.

There is also a confidential freephone Chief Inspector helpline that all prisoners have access to and they can ask for an independent prison monitor to visit them individually. The Chief Inspector is written to and contacted by families in particular, and there are opportunities therefore, and have been opportunities in the past, my Lady, for concerns to be raised about the treatment of young people --

LADY SMITH: Good.

MS DURKIN: -- and prisoners in general in prisons. The Chief Inspector will always investigate or raise

concerns, so far as it is able to do.

LADY SMITH: Good.

MS DURKIN: In relation to historic abuse, and as my Ladyship knows, the Chief Inspector wasn't able to provide direct evidence of historic abuses of children in Scottish prisons, and it also wasn't able to provide evidence on the scale and nature of that abuse.

LADY SMITH: Mm-hm.

MS DURKIN: This is because the Chief Inspector has no legislative detection function, no enforcement function with regard to child abuse. So, for example, it has no authority at all to request information on staff conduct, and no investigative powers in relation to staff conduct. Although what it will do is draw governors' attention to any allegations of staff abuse that are brought to its attention.

My Lady, in addition to that, it is only in a prison on average once every four years.

LADY SMITH: Yes.

MS DURKIN: Fairly limited involvement. I think from the Chief Inspector's position it would say that as its statutory remit is to inspect and monitor, its role is really focused on prevention as opposed to detection.

The evidence that Ms Sinclair-Gieben gave to the Inquiry, and in the written submission, was that

enforcement powers -- it was a specific question asked on whether enforcement powers should be given to the Chief Inspector. I have not been able to obtain confirmation that that remains the position from the new Chief Inspector, but that's the evidence and the position as matters stand.

LADY SMITH: Because otherwise things are just left hanging. The inspector may be in possession of something that as a matter of information is a matter of serious concern, but can't take it anywhere that's going to actually make a difference.

MS DURKIN: I think, in fairness, the Chief Inspector would say, my Lady, that it cannot take it anywhere itself but can pass on, and will always, always pass on information.

LADY SMITH: Absolutely, but the inspector doesn't have any power to make something happen.

MS DURKIN: Indeed.

LADY SMITH: Just tell somebody else, in a way fingers crossed that that somebody else will make something happen.

MS DURKIN: Indeed.

I turn now to abusive practices, my Lady.

At the time of Ms Sinclair-Gieben's evidence, all children were held in Polmont and the only exception to

that would be if there was a court date and a child needed to be held in another location in Scotland and could be held overnight in another prison.

There was evidence given to the Inquiry on the Year of Childhood survey 2021 that the Chief Inspector conducted in Polmont. This found that over 90 per cent of the respondents in Polmont under the age of 18 stated that they had felt safe at that time, and that was the evidence that was given to my Lady. However, the Chief Inspector would urge a degree of caution in relation to that particular part of the evidence. It was a small survey, there were only 13 participants, so that itself would lead to a degree of caution. The research also indicated that two-thirds of children in Polmont experienced less than two hours out of cell per day, and one third spent less than one hour a day out of cell at the weekend, and about 45 per cent of the children felt anxious or stressed.

However, every child who responded felt that the Scottish Prison Service staff cared for them and all but one felt able to reach out to them for help.

LADY SMITH: Yes.

MS DURKIN: There were several practices, my Lady, that in the Chief Inspector's view were abusive and have now been remedied and stopped, for example slopping out as

practised in the 1980s. That ended in Polmont in 2007.

Evidence was also given about the introduction of free phone calls from the privacy of young people's cells during the Covid-19 pandemic, and how important that was to children, allowing them to keep in touch with family members, and the opportunity as well to maintain contact via virtual visit video technology was another important development that occurred during the pandemic, underpinning contact with family and friends for young people in the prison estate. And also helping to counteract the risks that were imposed by isolation.

There was also evidence, my Lady, given in relation to the anachronistic nature of some prison rules across Scotland, and that modernisation and review was required in relation to some of these. The Chief Inspector has repeatedly criticised the use of random body strip searching in Scottish prisons, and this is particularly problematic in young offenders' institutions for females, because there is a requirement to search 20 per cent of all prisoners returning from the visiting room, and so in the female community custody units where there is only a very small number of females attending for visits, this increases each individual's likelihood of being body searched after a visit with family or friends.

LADY SMITH: Of course.

MS DURKIN: Of course, the Chief Inspector accepts that body searching is appropriate where there is intelligence to justify it, and in her evidence the Chief Inspector as was discussed the use of body scanners as a very effective and efficient technology. She did also emphasise as well, my Lady, and her evidence was there was actually no evidence in her view that random body strip searching was at all necessary.

In relation to complaints, the evidence was that there was a general lack of confidence in the prison complaints system and that is and remains an ongoing theme of all Chief Inspector's inspections. I set out in the closing submission the complaints process routes, but the Chief Inspector doesn't interfere with the process and, as my Lady has already indicated, has no ability to interfere with, for example, any of the complaints processes, but it would say that it does obtain intelligence from complaints and from prisoner requests to the independent monitors about the pressures and issues around the treatment of prisoners in prisons in general.

The monitors can investigate any matter that's referred to them, and may also help prisoners make use of the Scottish Prison Service complaints system. There

was evidence, and this would be reiterated by the Chief Inspector today, that prisoners are often very forthcoming with complaints, and happy to discuss complaints. That's contrary to long-held notions that there would be a reluctance to do so, and that was Ms Sinclair-Gieben's evidence.

Indeed, the Chief Inspector also finds in their inspections that prison staff themselves are very happy to discuss areas of concern where, for example, they have been frustrated at a particular policy or approach of the prison itself. Examples are given, for example towel provision, cutlery, clothing and access to showers, for example, will be matters raised by prison staff themselves to the Chief Inspector.

Turning now to restraint, my Lady. The Chief Inspector is always reviewing the use of force and the use of restraint in its inspection and monitoring work. That review process will include how often restraint was used, why, how it is followed up, how often is it videoed, whether it was planned or spontaneous, who is reviewing the incident and what assurances are in place to make sure lessons are learned. The Chief Inspector, as was is evidence, was that body-worn cameras are invaluable in this context, both to staff and to prisoners, and superior to CCTV.

LADY SMITH: Yes.

MS DURKIN: The Chief Inspector gave evidence on her experience from Australia, where young people felt safer when body cameras were in use, and the Scottish Prison Service have been conducting pilots on the use of body-worn cameras, and further piloting is, I believe, planned.

LADY SMITH: Good.

MS DURKIN: However, in general the Chief Inspector's evidence remains that the use of restraint has not been a cause for concern in Scottish prisons, and the Chief Inspector has been generally satisfied with the use of restraint. The issues that it has had tended to focus on the assurance process, so to what extent it has been properly reviewed, considered, but not the actual use of restraint in the particular context itself.

At the time evidence was given to my Lady, there were plans in place to increase the frequency of inspections in Polmont to annual inspections. That was to allow, my Lady may remember, bespoke standards for young people to be developed, particularly in line with the experience of the Care Inspectorate and in conjunction with the Care Inspectorate. Of course, children have now been removed from the prison estate.

LADY SMITH: Yes, yes.

MS DURKIN: Just finally on restraint, in 2019 evidence was given on an external assurance exercise that the then inspector carried out into the Scottish Prison Services review of restraint following the death of a prisoner and the Chief Inspector continues to support all moves towards pain-reducing restraint and I think there are pilots undertaken on that in Polmont, Stirling and Low Moss Prison.

My Lady, to conclude, the Chief Inspector would like to extend its thanks to all involved in the preparation and presentation of the Inquiry, and would pay particular tribute to all survivors of abuse who have given evidence to the Inquiry. Such abuse is wholly abhorrent and deeply disturbing. The Chief Inspector only has admiration for the bravery of those who have given evidence about the trauma they have suffered and trusts and hopes that the Inquiry's findings will prevent similar abuse occurring in the future.

LADY SMITH: Thank you very much, Ms Durkin, thank you.

MS DURKIN: If I can be of further assistance, my Lady.

LADY SMITH: I have no further questions, thank you very much.

Could I now turn to the Care Inspectorate and I see, Mr McClure, you are here to represent the Care Inspectorate.

Thank you for the written submission, but I invite you now to present your closing submissions.

Closing submissions by Mr McClure on behalf of the Care Inspectorate

MR MCCLURE: Thank you. Good morning, my Lady.

My Lady, as she says has my written submissions.

LADY SMITH: Do you have your microphone on?

MR MCCLURE: I do, my Lady, I am a little distance from it.

LADY SMITH: Can you get a little bit closer to it?

MR MCCLURE: I was being mindful of the instructions on the desk not to move it, my Lady.

LADY SMITH: It's all right, you can move it a little bit.

MR MCCLURE: Does that work better now?

LADY SMITH: That's better, thank you.

MR MCCLURE: As I say, my Lady, I have lodged written submissions and I adopt these. It is not my intention though to go through those verbatim, but to highlight a number of points within them this morning.

Firstly, my Lady, the Care Inspectorate would wish to acknowledge, as it has done before, that the courage of those who have come forward to give their account of the abuse they have suffered and its consequences for them.

The Care Inspectorate would also wish to reaffirm its position --

LADY SMITH: Mr McClure, I'm sorry to be a nuisance, I am still having difficulty hearing you, and others may have. Of course, you have the misfortune to be in the back row of the speakers this morning.

You can move the arm up and down, that might help.

MR MCCLURE: I shall try again, my Lady, is that an improvement?

LADY SMITH: That's coming through better, thank you.

MR MCCLURE: If it should fall off again, please let me know.

LADY SMITH: Thank you.

MR MCCLURE: The Care Inspectorate would wish also to reaffirm its position that as an learning organisation, it is receptive to findings and to recommendations which may help it to improve its practice and to better protect children and other vulnerable groups, services for whom fall within its statutory remit.

That's aligned with its commitment to continuous improvement, which is, of course, the same commitment that it expects from those that it regulates. It has been said many times in the course of this Inquiry, including several times by me, my Lady, that there is no scope for complacency where the safety and well-being of children and young people is concerned. While we may be confident that in many respects matters have

considerably improved over the decades which this Inquiry has considered, we can never regard the protection of children from abuse as a job completed, vigilance will always be essential.

The Care Inspectorate has continued to do all that it can to assist the Inquiry by way of the provision of documents and summary regulatory histories in relation to registered or, indeed, formerly registered care services which are of interest to the Inquiry, by the provision of a detailed report dated May 2023, and, of course, by way of oral evidence. It will continue to do all that it can to assist the Inquiry.

Before I embark on any more specific submissions, my Lady, I note that you had expressed yesterday an interest in having some understanding of a particular term, and that it might be helpful to address that now. The term was of course 'a relational approach to care'.

LADY SMITH: Yes, because I think the source of that is in the use by the Care Inspectorate.

MR MCCLURE: It is, my Lady, it was a quote from a Care Inspectorate report.

LADY SMITH: Yes, I would welcome an explanation, thank you, Mr McClure.

MR MCCLURE: I am advised, my Lady, that this term refers to paying attention to the significance of relationships

and to knowing that some children and young people will respond differently, that's to say better, to some staff than to others. It involves thinking about how this balance is managed in things like staff rotas, shift patterns and recruitment.

My understanding, my Lady, is that the term, when it is used in Care Inspectorate inspection reports, is used to describe the degree to which the culture of the service and the practices of leaders and staff recognise that the centrality of trusting and nurturing relationships with young people.

In the view of the Care Inspectorate, the best relational care would show itself in a deep understanding and appreciation of the individual impact of each child or young person's trauma. The practices, interventions, interactions and connections in response to that would then be individualised to the child on a consistent basis and based on respect, trust and unwavering commitment, all with the objective of enabling the child or young person to heal, grow and thrive.

LADY SMITH: Yes, thank you for that.

I wonder whether it needs to be recognised that it is not simply having a deep understanding and appreciation of the individual impact on a child or

young person of their own trauma, but understanding the specific features of that young person, for example if you take a young person who is neurodiverse, the best way to relate to them is probably going to be different from the way that member of staff needs to relate to a child who is not neurodiverse. That's nothing do with their trauma, it's just the way the child is. Do I have that right?

MR MCCLURE: Indeed, my Lady, I believe so.

I am slightly hampered by not having a very detailed knowledge beyond what I am able to set out today. I know that there are a number of academic papers which address this subject, and it might be helpful to the Inquiry to have the references for some of those.

LADY SMITH: It might be helpful to the Inspectorate as well. It sounds as though what you read me comes from guidance written by the Inspectorate, or something of that nature, do I have that right?

MR MCCLURE: I am not sure, my Lady. Given that the matter arose at a fairly late hour yesterday, I have gone straight to colleagues who ought to have a good working knowledge of this, and that's the explanation that they offered to me.

If there is perhaps more that can be offered, I am very happy to provide that --

LADY SMITH: Well, if you have it --

MR MCCLURE: -- at a later point.

LADY SMITH: -- and it is the way the Inspectorate work, that would be helpful. I say that because from what I hear, the use of that term, coming from the Inspectorate as it does, is then going into advice to providers, and they need to understand exactly what it means and what the Inspectorate think they need to do to do the job better.

MR MCCLURE: Indeed, my Lady, yes.

I am very happy to explore that further and to come back to the Inquiry.

LADY SMITH: Thank you.

MR MCCLURE: To move on, if my Lady is happy to do that?

LADY SMITH: Yes, thank you.

MR MCCLURE: While the Inquiry has before it only very limited applicant evidence regarding the period from 2002 when the Care Commission, to which the Care Inspectorate is the statutory successor, came into being, it has, of course, heard evidence at some length from Andrew Sloan and from Helen Happer. That was in relation to matters of history and current practice. The Inquiry has also had the benefit of hearing much more recently from Andrew Nelson, who is an inspector, in relation to a particular recent regulatory

interaction. I am referring, of course, to matters relating to St Mary's Kenmure, which the Inquiry heard evidence on, on 4 December last year.

LADY SMITH: Yes.

MR MCCLURE: Coming back in the first place, though, to the evidence of Ms Happer and Mr Sloan. They brought, in my submission, detailed knowledge coupled with considerable insight and analysis. That included, my Lady, their frank acknowledgements of the limitations of the regulatory regime operated by the Care Inspectorate and of regulation more generally.

Both of these witnesses spoke at some length of the challenges of regulating services for children and young people, and in particular of the difficulties in making children and young people feel confident in speaking freely with regulators, who may be seen as representing authority and who, by the nature of the inspector's work, have only very limited opportunities to build trusting relationships with those inspectors.

The evidence of both, though, I would submit, painted a picture of an organisation which has sought to innovate, sought to develop and refine its processes over its lifetime in order to best serve the interests of those receiving the range of services which it regulates, albeit that Helen Happer spoke of the tension

between getting through the necessary numbers of inspections, while retaining the capacity to follow up on matters of concern which may arise.

I shall perhaps come back to that later, my Lady.

LADY SMITH: Yes, yes.

MR MCCLURE: Turning now to the more particular matters on which the Inquiry has invited submissions, the Care Inspectorate proposes no specific findings in fact.

LADY SMITH: Actually, before you go to that, Mr McClure, because it is a general matter I am interested in, you may recall that in her evidence, Amanda Hatton from City of Edinburgh Council referred to recent discussions she had had with the Care Inspectorate about methodology, about referring to the developments of the work of Ofsted south of the border and so on. Do you recall what I am talking about?

MR MCCLURE: I do recall that, my Lady.

LADY SMITH: Can you give me any up-to-date picture of where those discussions have taken the Inspectorate, or what's happening in relation to what was talked about?

MR MCCLURE: I can't today, my Lady. I had taken Amanda Hatton at her word and was not surprised to hear that these discussions were ongoing. That, it seems to me, my Lady, seems to sit well with that picture that was presented by Helen Happer and by Andrew Sloan, of

an organisation that doesn't stand still and is always looking to do better.

LADY SMITH: Yes.

MR MCCLURE: But I hadn't investigated what the specifics of those discussions were. Again, it is something that I am very happy to provide that detail of.

LADY SMITH: Yes, I thought you might have done by today, because it certainly sounded like something that the Care Inspectorate ought to be interested in.

MR MCCLURE: I am sure it is, my Lady. I had anticipated a number of questions today, but not that particular one. But I am happy to come back with that information.

LADY SMITH: Yes, I would like to know what's happening and I can see there could be a range of responses starting with, 'Lots of good ideas were talked about, we would love to follow them up but we don't have the resources', to, 'Lots of ideas were talked about, we are particularly interested in A, B, C, and this is our plan, and you will see things changing in the future in that respect'. Or somewhere in the middle.

I think we need to know where that's going, if anywhere.

MR MCCLURE: Certainly, my Lady.

LADY SMITH: Thank you.

MR MCCLURE: I think things will change in the future,

because in my submission the picture that the Inquiry has is of an organisation which is always changing, is always doing things differently, is always seeking to do things better. It seems to me that were the Care Commission of 2002 to come along and have a look at the Care Inspectorate of 2025, it wouldn't recognise it in any way.

LADY SMITH: That can mean one of a number of things, and I won't press you on that, Mr McClure.

You were about to turn to particular factual matters. If you want to do that, that would be helpful, thank you.

MR MCCLURE: Yes, my Lady. As I say, I invite no specific findings in fact.

As I have said in my written submissions, my Lady, the Care Inspectorate doesn't acknowledge any specific or systemic failures relevant to the Inquiry's terms of reference. I would temper that, though, my Lady, by saying --

LADY SMITH: Sorry, it doesn't acknowledge any specific or systemic failures?

MR MCCLURE: That's correct, my Lady.

LADY SMITH: By whom?

MR MCCLURE: On its own part, my Lady.

LADY SMITH: Oh, right, on its own part, right.

MR MCCLURE: It speaks for itself at this point, my Lady.
LADY SMITH: Thank you.
MR MCCLURE: I think, my Lady, though, that has to be tempered by saying that of course there will be instances where things could have been done better. That will always be the case.
LADY SMITH: Well, let me test you by this, Mr McClure: we have heard a lot, as you know, about the report by Pauline McKinnon. You may or may not remember, but that report identified a long list of systemic failures on the part of City of Edinburgh Council. And none of those have been identified by the Care Inspectorate, and yet some of them looked quite glaring. Is that not pointing to the possibility of a systemic failure on the part of the Care Inspectorate itself?
MR MCCLURE: I think, my Lady, I would say in relation to that, that having a regulator which carries out regular inspections can make things better, and the Inquiry has seen a recent example of how shining a light on failures within a specific care service has helped, or is helping to make it better. But having a regulator cannot mean that things will never go wrong and having a regulator cannot be taken as a guarantee that every failing will be detected. It can help, but the regulator, I think, as I have submitted before, my Lady, is a body

constrained by statute. It has statutory processes to follow. And it has to act on the basis of the evidence that it finds.

Already this morning, my Lady, Mr Batchelor has acknowledged that of course all the Care Inspectorate can do is to have a snapshot at the point when it inspects.

My Lady has heard from Helen Happer of some of the difficulties in inspecting services for children and young people. If staff in the service who are looking on and seeing things which they find unacceptable don't feel confident or are discouraged from speaking up about that, if children in the service don't feel confident in talking about their experiences to inspectors, then they are already operating at a considerable disadvantage.

I would suggest that it would be overly optimistic to assume that inspection will detect every possible failing.

LADY SMITH: Pauline McKinnon spoke of seeing and identifying a toxic culture, and she gave a lot of details that pointed to a toxic culture, that was of long standing. Is it really good enough for the Inspectorate to say, 'Well, our role is quite limited, we go in and we do a snapshot, we come away, and we could miss something like that'?

Or does it point to the Inspectorate, a healthy, growing reflective inspectorate, needing to say to itself it has to change its systems if a toxic culture was ongoing under its nose and it never saw it?

MR MCCLURE: Of course it always wants to do better, my Lady, of course it does.

LADY SMITH: Yes. You say it always wants to do better? Always wants or always needs to do better?

MR MCCLURE: Both, my Lady.

LADY SMITH: Thank you, Mr McClure.

I am sorry, I diverted you. Where were we going next?

MR MCCLURE: I was going to invite my Lady to, in looking at the Inspectorate, be mindful of the context in which it works and the range and number of social services that it is charged with inspecting and regulating. There are 13 defined types of care services for both children and adults that it is charged with regulating. At present they number approximately 11,000 in total. That's of course alongside its role in the inspection of social work services. So it is no small undertaking, my Lady.

The Inquiry, as I alluded to earlier, my Lady, has had the opportunity recently to consider an example of a recent interaction with a particular care service, namely St Mary's Kenmure. That's of course a secure

accommodation service which has been the subject of consideration by the Inquiry.

LADY SMITH: Mr McClure, I am sorry, can you get nearer the microphone, we are not hearing you up here.

MR MCCLURE: I shall try again, my Lady.

LADY SMITH: If you can lean forward and get into a better position and just go back to what you were saying, because I am sure it is important.

MR MCCLURE: Yes, my Lady, the Inquiry has had the recent opportunity to consider an example of a current interaction with a particular care service, and I am referring again, of course, to St Mary's Kenmure.

LADY SMITH: Yes.

MR MCCLURE: While the Inquiry's interactions with the Care Inspectorate have thus far been with managers, this allowed the Inquiry to hear evidence from an inspector working on the front line, so to speak. That was of course in the form of Andrew Nelson, who gave evidence in early December.

If there were criticisms of the Care Inspectorate implicit in the examination of Mr Nelson by the Inquiry counsel, these appeared to me to be firstly that the findings which informed the enforcement action commenced in October 2024 were not new, in the sense that they reflected the nature of findings which have been the

subject of previous reporting and previous requirements of the service.

The implication, my Lady, was that that suggested a lack of effectiveness on the part of the Care Inspectorate. While it is acknowledged, of course, that there is a degree of consistency in the subject matter of the findings of successive reports and requirements that have been made, I would say it doesn't follow from that that the severity of those failings had been consistent over time. It seems to me entirely possible that issues which existed but which were not critical at one inspection to have developed or worsened significantly by the time of a subsequent inspection. Ultimately, in September 2024, capturing something more serious, and far more serious in my submission, than it had previously done.

The second of those potential criticisms seems to me to be that on the expiry of the initial timescales for compliance with the numbered improvements set out in the improvement notice of 4 October 2024, there had been no proposal to cancel the registration of St Mary's. My Lady will see that in my written submissions I have pointed to the relevant provision in the 2010 Act, which creates a power and not a duty to make such a proposal.

LADY SMITH: Where exactly in your submissions do you deal

with that, Mr McClure?

MR MCCLURE: Bear with me for one moment, my Lady.

Paragraph 10.2, my Lady.

LADY SMITH: 10.2, thank you. This is where you are dealing with the 4 October last year improvement notice.

MR MCCLURE: Indeed, my Lady.

LADY SMITH: The point that the deadline in that notice expired without the required improvements having been made in full --

MR MCCLURE: Yes, my Lady.

LADY SMITH: -- but no proposal to cancel registration followed on that?

MR MCCLURE: Yes, I detected, perhaps, a little surprise at that.

LADY SMITH: Yes.

MR MCCLURE: I would say in relation to that, that section 64.1 of the 2010 Act gives a power to make a proposal to cancel registration, it doesn't impose a duty.

LADY SMITH: I don't think that was ever suggested, but it surely raises a requirement for the Inspectorate to address the question, and however it's answered by the Inspectorate, to have good reasons for answering it either, 'Yes, we are going to have to propose cancellation', or, 'No, we are not'.

MR MCCLURE: Absolutely, my Lady. I think that that's the thrust of my submission, that one option, and it is an option which is not uncommon, is to recognise that progress is being made and that is significant progress and to allow an extended period for compliance. As I say, that's not uncommon and seems to me not only a reasonable exercise of that discretion, but also consistent with the general duty of furthering improvement in the quality of care services, which is set out at section 44.1(b) of the 2010 Act.

I think the third and final potential criticism that I detected, my Lady, was the suggestion that there should have been more rigorous follow up on requirements made in previous inspection reports. I can say that the Care Inspectorate would aim to do that, to follow up on such requirements, but plainly in this case they had not been followed up when the timescales had expired. Whether it ought to be regarded as appropriate, as I say, perhaps depends on the view taken of the role of the regulator. In the course of Helen Happer's evidence, my Lady compared the role of inspection to valuable consultancy, and just to pursue that a little bit, a consultant might be expected to examine, to report, and to make recommendations, but wouldn't necessarily be there to oversee implementation. That

seems to me, my Lady, consistent with the evidence of Helen Happer, to the effect that the primary responsibility for the provision of a safe environment lies with the person providing a care service.

LADY SMITH: I see you go on in your written submission, Mr McClure, to suggest it is not unreasonable to expect that requirements will be proactively addressed by the service provider, and they can be left to be reviewed at the next inspection.

Now, the next inspection may be quite some time after that, yes?

MR MCCLURE: It may be, my Lady.

LADY SMITH: But in the meanwhile children are day, and daily, in that service being provided for and possibly without the requirements having been addressed at all. Is that not a problem?

MR MCCLURE: I would say, my Lady, that the ideal is that the Care Inspectorate would be in a position to follow up on those on the expiry of the timescales.

LADY SMITH: Yes.

MR MCCLURE: Sitting alongside that, though, it is also, in my submission, a reasonable expectation of those who are providing services that they will take those requirements seriously, and that they will do something about it.

LADY SMITH: A reasonable expectation of the Care Inspectorate?

MR MCCLURE: I think it is a reasonable expectation for my Lady to hold.

LADY SMITH: I am to expect that the service will follow up diligently on the requirements?

MR MCCLURE: I think we should all be entitled to expect that, my Lady.

LADY SMITH: That sounds dangerously near proceeding on the basis of assumption. What we have seen, Mr McClure, over past decades is making assumptions that all will be well in relation to taking care of children is a very dangerous activity, isn't that right?

MR MCCLURE: Well, indeed, my Lady. I think what I am saying is that the Care Inspectorate shouldn't have to follow up on these inspections, but arguably it does. And that's the position.

LADY SMITH: Okay.

MR MCCLURE: That is the aim that it holds.

However, that happens against the background of an inspection plan which is constantly evolving, based on risks, based on emerging intelligence, and where priorities don't necessarily allow that to happen, or where priorities and resources don't always allow that to happen.

LADY SMITH: Yes.

MR MCCLURE: Certainly in making recommendations, my Lady may wish to have in her mind the question of resources to match any particular recommendations for action that come out of this Inquiry.

LADY SMITH: Yes.

MR MCCLURE: But, of course, my Lady, events in relation to St Mary's Kenmure, which have been spoken about recently, are a good example of that, where an emerging situation requires significant input from the Inspectorate, and by its very nature will have a detrimental effect on the other things that it can do. That's an example of that inspection plan having to flex to respond to emerging circumstances.

LADY SMITH: Okay, thank you.

MR MCCLURE: I would like to move on, my Lady, to look at some past changes in policy practice, not so much legislation, which might have impacted on the protection of children.

As my Lady will be aware from expert evidence, there has been little substantive change in the relevant legislative landscape since 2002. But my Lady has heard of a number of changes which have taken place in the regulation of residential care services for children, and they have been substantial in some cases. I would

highlight just a few of those.

The introduction of the quality assessment framework and associated gradings in 2008, and subsequent refinements of that system, for example changes made in 2016. My Lady will find that at page 16 of the Care Inspectorate's report of May 2023.

The creation of specialist national teams of inspectors during the first two years or so of the Care Inspectorate's existence.

The introduction of revised methodology for inspection of school care accommodation in the form of residential special schools and care homes for children and young people in 2019 and, as I understand it, my Lady, for secure accommodation in the following year.

The introduction of key question 7 in 2022, and my Lady will recall that that's something that was spoken about by Helen Happer and Andrew Sloan in terms of being a tool that brings together all the other things that the Care Inspectorate looks at under one heading.

LADY SMITH: Yes.

MR MCCLURE: Moving on to current work which might have an impact on the protection of children from abuse, again my Lady was given some examples by Ms Happer and by Mr Sloan, such as that the considerable work flowing from the Independent Care Review and from The Promise,

and also a very substantial piece of ICT development work which is designed to allow not only the replacement of legacy systems but to help ensure that all relevant information and intelligence is held in an appropriate and accessible manner to best inform regulatory work and make the best possible use of intelligence.

Clearly, my Lady, the Care Inspectorate acquires in the course of its day-to-day business, as the Inquiry knows, a great deal of information, but acknowledges that there is a great opportunity to improve what it can know based on that information which it holds and how that information can be organised to better inform how the Care Inspectorate does its work.

Finally, my Lady, ongoing work designed to improve the extent to which social workers engage with and share information with the Care Inspectorate. My Lady might recall that Andrew Sloan spoke about that with really quite significant enthusiasm when he gave evidence a long time ago, in September 2023.

Moving on, my Lady, the Care Inspectorate has no particular observations to make upon themes emerging from Phase 8 but in conclusion, my Lady, I would like to remind the Inquiry of the invitation it extended to the Care Inspectorate in preparing its report for Phase 8 to suggest recommendations for legislative change.

A number of areas in this regard were raised in section 15 of the report of May 2023, and they were again spoken to by Helen Happer and Andrew Sloan. The principal elements of that were: a proposal for regulation at provider level, rather than at individual service level; a review of the legislative provisions relating to the registration of care services; the regulation of agencies providing workers to residential childcare services; and review of the criteria thresholds and processes for implementing enforcement powers.

I should say, my Lady, by way of update that in relation to the first of these proposals, and that was regulation at provider level, I will next week be having some initial discussions with relevant Scottish Government colleagues and the Care Inspectorate Wales.

The Care Inspectorate Wales operates a system, my Lady, where care services are not simply registered at service level, but there is an element of registration at provider level also. That is certainly a discussion which is being progressed.

LADY SMITH: That's at both levels in Wales there needs to be registration; is that correct?

MR MCCLURE: That's as I understand it, my Lady, yes.

Individual services are registered, but as

I understand it, the provider also holds a registration. That has the potential to open the door to things like enforcement action taken at provider level, and I am sure my Lady can see how, where there are systemic issues, that might be a good opportunity to address those, rather than having to do that with numerous different registered services.

LADY SMITH: Will those discussions also cover the possibility of registration of agencies, which was discussed in evidence here? The agencies providing staff.

MR MCCLURE: My recollection, my Lady, was that there was a potential for that to be taken forward in the legislation relating to the National Care Service.

LADY SMITH: Yes.

MR MCCLURE: There is of course some doubt about the status of that and what proposals will be left in that.

LADY SMITH: Mm-hm.

MR MCCLURE: Certainly, my Lady, I am also in discussion with Scottish Government colleagues in relation to the last of those points. That is a review of the criteria thresholds and processes for implementing enforcement powers. I have suggested that on the basis that the initial discussion that I referred my Lady to has the potential to result in legislative change, and if there

is to be legislative change, then it would be a good opportunity to take that forward.

In doing that, my Lady, I didn't refer specifically to the regulation of agencies. My recollection is that that was a recommendation made by the Care Inspectorate, and adopted by the review of 2020.

LADY SMITH: Yes.

MR MCCLURE: But while my recollection was that that may be taken forward as part of the National Care Service legislation, it is something that I would have to check upon.

LADY SMITH: I see.

Just going back to the dual level of registration at provider level and at service level, for those listening to or reading this evidence who are trying to remind themselves of examples of each, can you give me one in Scotland who might then be a provider that would have to be registered and who might then be, at service level, who would have to be registered?

MR MCCLURE: My Lady has put me on the spot to try to think of individual services. A number of the services that have been discussed recently, for example St Mary's Kenmure, is indeed a standalone service. There are a number of large organisations which operate a number of care homes for older people --

LADY SMITH: Yes.
MR MCCLURE: -- across the country. An example of that might be Meallmore which has a number of care homes, or HC-One, my Lady.
LADY SMITH: Yes.
MR MCCLURE: These are examples of organisations which have a number of care homes for older people, and so --
LADY SMITH: Yes. I don't think, if I have it right as to the landscape at the moment, it would actually affect provision of residential care for children, would it? Because, as you say, the secure units in Scotland are all run by private organisations, voluntary providers. Where else would it touch, anywhere?
MR MCCLURE: There may be providers who operate more than one residential special school, which would be registered in the form of --
LADY SMITH: Of course.
MR MCCLURE: -- school care accommodation, my Lady.
LADY SMITH: Of course, the additional support need schools, for example.
MR MCCLURE: Yes, my Lady.
I would struggle to give an example, but I think that there may well be some examples of those.
LADY SMITH: Yes.
MR MCCLURE: Of course this phase of the Inquiry's work,

while it has looked recently at secure accommodation, has in its earlier part looked at other forms of residential care for children.

LADY SMITH: It may be something that we want to look at again when we get to Phase 9, looking at establishments for healthcare, additional support needs and children with disabilities.

MR MCCLURE: Indeed, my Lady, it may well be relevant there too.

LADY SMITH: Thank you.

MR MCCLURE: Those, my Lady, are my submissions, unless I can be of further assistance.

One matter which occurs to me to ask is whether my Lady would like any updating information in relation to St Mary's. I know that there was an update provided on behalf of St Mary's earlier in the week, and I don't take issue with what was said there.

LADY SMITH: Yes, please, is the answer to that, thank you Mr McClure.

MR MCCLURE: I am very happy to do that, my Lady.

LADY SMITH: Very well, I will rise now for the morning break.

Then after the morning break we will move on to the Crown Office and Procurator Fiscal Service, and Scottish Government and Police Scotland.

Thank you.

(11.30 am)

(A short break)

(11.45 am)

LADY SMITH: Welcome back. I would now like to turn, please, to Clare Whyte for Police Scotland.

Ms Whyte, when you are ready.

Closing submissions by Ms Whyte on behalf of Police Scotland

MS WHYTE: Good morning, my Lady.

I am grateful for the opportunity to make this closing submission on behalf of the Chief Constable of the Police Service of Scotland.

Firstly, the Chief Constable wishes to express sympathy to all survivors of childhood abuse, including survivors who have experienced abuse within any of the 39 establishments featured within this case study. The Chief Constable would also like to take this opportunity to reassure survivors, the Inquiry and the people of Scotland that Police Scotland is fully committed to thoroughly investigating all forms of child abuse that has taken place in Scotland, regardless of when it happened or who was involved.

Police Scotland remains committed to delivering its response to the Inquiry, and ensuring that all relevant information held is provided in compliance with the

terms of notices issued under the Inquiries Act 2005. This information includes policies, procedures and documents relating to investigations into the abuse and neglect of children within the establishments featured within this case study.

Police Scotland also wishes to inform the Inquiry that, in keeping with its continued commitment to non-recent child abuse investigations, it is currently investigating non-recent abuse within a number of these establishments. These investigations have arisen out of both the review of previous investigations and new reports of abuse from survivors.

Police Scotland continues to build on its engagement with survivors of childhood abuse, seeking views and consulting with survivors, support services and statutory partners to enhance public confidence and improve service provision. Police Scotland recognises the importance of using organisational learning to effect continuous improvement to ensure its staff have the best skills and capabilities to deal with the specific needs of survivors of child abuse.

As such, Police Scotland will take into account any good practice or areas of learning that may be identified from this phase of the Inquiry hearings as part of its commitment to developing and improving its

service provision.

LADY SMITH: Do I take it from the way that's put that Police Scotland are not offering me any identification of good practice or areas of learning that they have identified from Phase 8 of our hearings, namely that phase that began in September 2023 and is finishing today?

MS WHYTE: I think Police Scotland would recognise that there were an increased number of submissions during the evidence of some of the applicants that related to negative experiences of the police, and largely related to service delivery.

LADY SMITH: Yes.

MS WHYTE: The police, in terms of progressing some of those instances, have been frustrated somewhat in terms of the ... unless the applicants themselves actually wish to progress the complaints, it can be quite difficult for the police to get the necessary information, particularly since a lot of the complaints that were made were now of quite some vintage, my Lady.

I am afraid that I am not able to provide you with specific instances, but I can certainly go back to those instructing me and check that, if that would be helpful.

LADY SMITH: I was interested to know if there was anything particular that had occurred to them that was important

learning for them. If you take, for example, a witness like, I can name him, Killian Steele, who was seriously upset by and critical of the prosecution services in their entirety in relation to his experience of one prolific abuser. I just wondered whether I could be assured that Police Scotland were noting evidence like that, reflecting on it and learning from it, namely that that could happen again if they are not aware of how it happened in the past, and how somebody at his stage of life, decades later, is left impacted by his bad experience then.

MS WHYTE: I think you can be assured of that, my Lady. Certainly this is something that Police Scotland has noted, it has noted each of the instances where there have been negative experiences reflected upon in terms of the evidence made and given by applicants.

LADY SMITH: Good, it is very important that they do. Thank you.

Sorry, I interrupted.

MS WHYTE: Finally, Police Scotland remains committed to child protection, both locally as a core statutory child protection agency, and nationally, in partnership with multi-agency and strategic leadership groups, to implement continuous improvements and make a positive contribution to protecting Scotland's children, both now

and in the future.

LADY SMITH: Thank you.

Turning to Crown Office and Procurator Fiscal Service, Ms Shand, when you are ready.

Closing submissions by Ms Shand on behalf of the Crown Office and Procurator Fiscal Service

MS SHAND: My Lady, thank you.

My Lady, I am grateful for the opportunity to make a closing submission to the Inquiry on behalf of the Lord Advocate.

As with previous closing submissions, this one is brief as it is understood that the primary focus of the Inquiry's present case study is not at this time on the Crown, although that will of course change during the anticipated criminal justice case study.

In relation to the present case study, the Inquiry has of course heard of the evidence of physical, sexual and psychological abuse of children within young offenders' institutions, secure units and List D schools in Scotland.

Evidence has been provided to the Inquiry that some of this abuse was reported to and thereafter investigated by the Crown Office and Procurator Fiscal Service, COPFS. Indeed, the Inquiry has heard that prosecutorial action was subsequently taken by COPFS in

respect of a number of individuals against whom allegations of abuse were made.

During the present case study, the Inquiry has heard from individuals who were also complainers in criminal proceedings or prosecutions. The Lord Advocate acknowledges that some of these complainers were critical of COPFS decision making and communication with them. These complainers gave evidence that the standard of service they received from the Crown fell below that which the organisation strives to achieve.

That evidence, alongside all the other evidence given to the Inquiry, has been and will continue to be very carefully considered by COPFS. The Lord Advocate is committed to ensuring that COPFS communicates with survivors clearly and effectively and, moreover, that COPFS continues to reflect upon how that communication can be improved. The organisation is committed to victims and witnesses being at the heart of what it does and to delivering a trauma-informed service.

In terms of how COPFS is seeking to learn from the evidence being led at the Inquiry, and also from its understanding of the Inquiry's own approach to its work, the Lord Advocate wishes to draw your attention to the following:

First, as explained at the close of the foster care

case study, criticisms of COPFS at the Inquiry was being fed into the review of child deaths and non-accidental injuries in children, which was commissioned by the Solicitor General in September 2022. The work of this review is now complete, its report was published internally in November 2024, and the main themes of the review and its recommendations were made public.

The report acknowledges that themes which have emerged from the Inquiry's evidence relevant to the investigation of the deaths of children in care is the importance of record keeping to survivors of institutional abuse and the importance of accurate communication with bereaved nearest relatives.

The report also notes the learning which can be drawn from the approach taken by the Inquiry, specifically the trauma-informed approach, which has been embedded from the outset of the Inquiry and is an organisational approach from the top down. In this regard, staff from the Victim Information and Advice service, generally shortened to VIA, and the law officers benefited from meeting with staff from the Inquiry.

One of the recommendations from the child deaths review is that there should be mandatory training for all COPFS practitioners carrying out this work, which

should include a course on communication with nearest bereaved relatives. Another recommendation is that a COPFS child death and serious injuries improvement board should be established to implement the recommendations of this review.

A member of the COPFS Scottish Child Abuse Inquiry team now sits on this board to ensure that the Inquiry team continues to share learning gained from considering the evidence given to this Inquiry.

A further recommendation which may be of interest to the Inquiry is that the recently established COPFS children's network for all practitioners involved in this work should meet quarterly to share learning, raise awareness of these cases and provide further support for those involved in this work.

LADY SMITH: Can you explain a little bit more about this children's network, Ms Shand, what is it?

MS SHAND: Sorry, my Lady, just give me one moment.

I think it is an initiative, my Lady, to bring together learning for all those involved in prosecutorial work and investigatory work involving children, including children who have been abused in institutions.

LADY SMITH: This is all people working within the Crown Office and Procurator Fiscal Service, is it?

MS SHAND: It is, it is.

As I say, the initiative is for them to meet quarterly to share learning, raise awareness of the types of cases that COPFS are dealing with involving children and provide further support for those involved in the work.

Two COPFS staff members who are involved in aspects of the Inquiry's work from the Crown perspective attend this network. On 25 September 2024, one of those staff members provided a training on restraint to share learning about the approach being taken in the prosecution of cases concerning this area. I understand that that involved in essence: what restraint is; how it interacts with the criminal law, in particular the law of assault; and what circumstances, if any, it might be justified on the grounds of safety so as not to constitute a crime.

LADY SMITH: Yes.

MS SHAND: Second, in relation to COPFS commitment to becoming a trauma-informed organisation, a Principal Procurator Fiscal Depute has been appointed to a new role which comprises acting as strategy lead for trauma-informed practices and overseeing the project of implementing the trauma-informed justice framework within COPFS. Mandatory online training on becoming

trauma-informed has been rolled out for all staff and further training will be launched soon.

COPFS recognises however that whilst training and awareness are vital to becoming a trauma-informed organisation, this is a long term whole-system change, rooted in culture, and will involve looking at every aspect of its service through a trauma-informed lens. The newly appointed Principal Procurator Fiscal Depute will lead on this ongoing process of improvement, based on the needs of COPFS service users.

Thirdly, the COPFS Scottish Child Abuse Inquiry review team, which is the team dedicated to investigating cases which involve abuse in institutions, has, since July 2024, increased its Victim Information and Advice service, VIA, resource, from one to two VIA officers. These officers work exclusively with the victims of child abuse in residential care settings, supporting them through the criminal justice process from receipt of the police report to the conclusion of the case in court.

Crucially, these review team VIA officers work closely with the prosecutors in the Scottish Child Abuse Inquiry review and Scottish Child Abuse Inquiry COPFS teams, drawing on the learning of the Inquiry and developing the specialism in this area of work to

improve the service and support they provide to victims.

Fourth, in 2024, the VIA modernisation programme, which was also referred to during the foster care study closing submission, reviewed all the VIA letter templates which COPFS sends to victims, witnesses and bereaved relatives. There was significant input into the review from VIA and legal staff members and a range of external support agencies, including advice from a victim support Scotland reference group, consisting of victims, witnesses and bereaved relatives with lived experience.

Use was made of the Scottish Government's recently commissioned guide to written communication with people affected by crime, People at Heart, to help ensure the language and format of the letters was trauma-informed. Letters for children were reviewed separately with external specialist support, to make sure they are aligned with the new United Nations Convention on the Rights of the Child legislation.

Reviewing these letter templates has been an important step in improving the organisation's service to victims, witnesses and bereaved relatives. As a result of the review, letters are comprehensive, clearly worded and trauma-informed in that the language and approach are sensitive to the recipient's

experiences and aimed to reduce the risk of retraumatisation in line with trauma-informed practice.

The VIA modernisation programme continues to take on board feedback from members of staff, as well as victims and witnesses, with the intention that further enhanced versions of VIA letter templates will be issued early this year.

Finally, and again as I explained at the close of the foster care case study, criticism of COPFS and Inquiry evidence is also being fed into the sexual offences review which is ongoing. The review was announced by the Lord Advocate in December 2021, with the aim to consider how COPFS deals with reports of sexual offences, whether there could be improvements, and if so, to make recommendations for change. The evidence-gathering stage of the review has been concluded and COPFS await the findings and recommendations of the review.

The Lord Advocate will update the Inquiry once the review is published.

In conclusion, my Lady, may I repeat the Lord Advocate's ongoing commitment to supporting the work of the Inquiry, and to contributing, both positively and constructively, to its work, and also to ensuring the fair, effective and rigorous prosecution of crime in the

public interest for all members of society, including the most vulnerable.

Thank you, my Lady.

LADY SMITH: Thank you very much, Ms Shand.

I would like to turn, please, to closing submissions for Scottish Ministers. Ms O'Neill, when you are ready.

Closing submissions by Ms O'Neill on behalf of the Scottish Ministers

MS O'NEILL: Good afternoon, my Lady, I appear on behalf of the Scottish Ministers, the Scottish Prison Service and Education Scotland.

My Lady, I adopt what is a fairly lengthy written submission.

LADY SMITH: Yes.

MS O'NEILL: It could have been longer, but what has been attempted in that written submission is not to address all of the issues that the Inquiry has heard in this phase but to draw out some of the key issues in which the Scottish Government has a particular interest.

My Lady, I intend to speak to most if not all of the note, but I will also pick up on a number of points that I am aware have been raised by the Inquiry and others in the course of this week's submissions, and also a point raised with me this morning by Inquiry counsel.

LADY SMITH: Thank you.

MS O'NEILL: My Lady, these submissions supplement the interim closing submissions that were made in December 2023. Those dealt specifically with the evidence of abuse experienced by children in the care of the Scottish Prison Service and its predecessors, and I am not proposing to repeat that material this afternoon. But I will come back to the apology that was made at the conclusion of that part of the Inquiry's work, and also update the Inquiry on the outcome of the fatal accident inquiry into the deaths of Katie Allan and William Lindsay.

LADY SMITH: Thank you.

MS O'NEILL: My Lady, the second part of the written submission deals with the Scottish Ministers' interest in this phase. I had not intended to speak to this, but it does relate to a point that was raised with me this morning your Ladyship.

LADY SMITH: Could I just interrupt for a moment.

MS O'NEILL: Yes, my Lady.

LADY SMITH: Ms O'Neill, I don't want you to feel under pressure to rush through this, because the Scottish Ministers' role is very important, it has been very important throughout this phase.

MS O'NEILL: I am sorry, my Lady, I was both naturally speeding up in an unhelpful way and also having regard

to the 30 minute estimate that was given before we began.

LADY SMITH: Well, you will see where we are, and I would rather you go over 30 minutes to make sure that we have covered everything the Scottish Ministers should cover if necessary.

MS O'NEILL: My Lady, I intend to say more in terms of what is in the submission, than less, given that some people will not see the written submission and will be reading the transcript only.

LADY SMITH: Of course.

MS O'NEILL: My Lady, section 2 does deal with the Scottish Ministers' interests in Phase 8. At paragraph 2.3, it is said that the Scottish Government held responsibility directly for children in custody, since devolution in 1999, but is also answerable to the Inquiry and to applicants for abuse that took place in prisons and young offenders' institutions during the earlier period covered by the Inquiry's terms of reference.

It is also then said that separately, although statutory responsibility for providing and arranging for secure care lies most often with local authorities, the Scottish Ministers have a range of overarching policy responsibilities in relation to the way in which secure accommodation services are provided to children, and

have a range of statutory powers and duties regarding the establishment's subject to investigation in this phase, including in relation to inspection of schools within secure accommodation.

My Lady, those paragraphs were intended to acknowledge Scottish Government's responsibilities for a wide range of the matters dealt with in this phase. Mr Peoples did raise with me this morning whether Scottish Government might be more explicit about acknowledgement of responsibility and if there is a lack of explicitness in those submissions, that's my responsibility, rather than that of those instructing me.

To be clear, my Lady, Scottish Government accepts that the state for the whole period of investigation of the Inquiry had policy responsibility for the overarching framework and in some cases direct operational responsibility for delivery of services, including in relation to provision of resources.

LADY SMITH: Mm-hm.

MS O'NEILL: It accepts that in both those capacities there were failures, and that those failures will have contributed to conditions that allowed abuse to occur.

My Lady, that is in connection with failures in relation to resource and funding, but also in relation

to the timing of the putting in place of regulatory regimes, for example in relation to qualifications.

LADY SMITH: Yes, that's a stark example in a way, because we heard about the development in 2016, was it, of the benchmark as assessed by SSSC for the appropriate qualification, I think a Scottish Credit Qualification framework, and it should be up at level 9, and hadn't been implemented when we heard evidence from Maree Allison.

MS O'NEILL: My Lady, I will come back to that very specific point. The acknowledgement that I just made was in relation to the regulatory history in general --

LADY SMITH: I see, thank you.

MS O'NEILL: -- where I think your Ladyship has had evidence from various witnesses that at various stages throughout the whole period of the Inquiry's investigation, steps might have been taken by the state sooner to change the regulatory regime.

LADY SMITH: Thank you.

MS O'NEILL: My Lady, the acknowledgement is deliberately high level and broad.

LADY SMITH: Thank you.

MS O'NEILL: I don't have specific instructions on specific failures in respect of which I can make submissions, but I don't intend to do so and I don't intend or understand

the Inquiry to expect that of Scottish Government.

LADY SMITH: Thank you.

MS O'NEILL: My Lady, I want to move on to the section of the submission dealing with abuse experienced by children and as with other participants this morning, Scottish Ministers do not make detailed submissions on the evidence of abuse heard by the Inquiry during this case study or make proposals in relation to specific findings of fact.

However, Scottish Ministers would wish it to be made clear to the applicants who have given evidence that the Scottish Government has listened to that evidence and continues to listen to that evidence. The Scottish Government accepts and believes the evidence that has been given by applicants about the abuse that they have experienced.

LADY SMITH: Thank you.

MS O'NEILL: My Lady, Scottish Ministers also acknowledge the very substantial nature of this phase of the Inquiry's work, dealing with 39 establishments, some of which operated over multiple sites, and the experiences of applicants ranging across many decades. Ministers recognise and thank the Inquiry for the work that has been involved in conducting this phase, and it is clear from the evidence, my Lady, that applicants continue to

find the process of giving evidence to be an important and valuable one.

It is, particularly in the context of this phase, impossible to do justice to all of the evidence that has been heard over the last 13 months, or to convey the nature, scale and impact of the sexual, physical and emotional abuse and neglect suffered by those who gave evidence in this phase. The Inquiry has heard evidence from applicants who were children in these institutions in the 1950s, 1960s, 1970s, 1980s, 1990s and 2000s, and I have perhaps missed a decade or two. The themes that emerge from the evidence are entirely consistent with those that have been illustrated by evidence given in earlier phases of the Inquiry's work.

My Lady, I am always hesitant to pick out individual examples, given the vast amount of evidence that there is, but as is said in paragraph 3.7 of the submission, one striking element of the evidence in this phase concerned the reasons why children were committed to care, and I think Mr Batchelor also made reference to this in his submission. The punitive use of compulsory care as a response to behaviour that was itself a response to poverty and other forms of need emerges clearly from the evidence.

On the first day of Chapter 2, 'David', who was by

then 80, recalled receiving a criminal record at the age of eight because he had stolen potatoes from a field to help support his mother. He was later sent to St Ninian's Gartmore, because he had, with others, taken money from a purse.

On the same day, 'Andrew' gave evidence that he was sent to St Ninian's in the 1950s because of failures to attend school that were as a result of illness and poverty.

Indeed, 'Anderson', who gave evidence on 16 January last year, described the intervention by social workers in the 1960s which resulted in him and his siblings being separated and placed in different care environments as being motivated by a desire to give his parents respite from the slum conditions in which they lived. The evidence illustrates that this use of residential care as a response to underlying need continued throughout the decades.

'Alec's' evidence from 15 February last year was to the effect that he was sent to a List D school because of truanting, that was itself a response to bullying.

My Lady, once placed in a care environment, the applicants who gave evidence describe being subjected to the most extreme physical abuse, sexual abuse, including rape, and emotional abuse and degradation. Physical

abuse included regular and violent restraint and also involved forced administration of medication, including in the 1990s at Kerelaw through the forced administration of the contraceptive pill.

Sexual abuse included being exploited by those responsible for their care by making them available to other adults outside the institution, who also abused them. It also included peer-on-peer abuse.

Abuse included cruel punishments such as withdrawal of weekend home leave privileges, that led in turn to damage to family relationships.

Many, many applicants gave evidence about the failure of those responsible for their care to involve them in decision making about their care, or even to communicate what decisions had been taken about them.

Systemic failures that are clear from the evidence include failures of inspection, in some cases because there were no inspections at all, in others because inspection activity took place but did not result in steps being taken to remedy identified failures and in others because inspection activity was invisible to children, and they had no opportunity to make their voices heard.

I think Counsel to the Inquiry made reference to Education Scotland's report on the opening day this week

of closing submissions. The paragraph which I have quoted makes reference to the fact that there were significant gaps in records of inspection and significant gaps in inspection activity in respect of a number of these institutions.

Systemic failures that are clear from the evidence of applicants also included failures to deliver any or adequate education to children in these settings. Some applicants gave evidence that they had received a good education in care, but many others gave evidence about the inadequacy of their education.

'Buster' referred to his education at Balgowan as being 'incredibly basic, it was primary school and Year 2 or 3 maybe'.

In relation to St Ninian's, 'Glen' gave evidence that 'they didn't seem to care about my lack of education' and that what he did receive was nothing you would expect to be getting if you were in a secondary school setting.

Some children saw their potential recognised and supported by individual members of staff, who were otherwise working within extremely limited environments.

One who stands out is 'Jessica', who gave evidence about the support of Mrs Vernon at Calder House and how that member of staff 'fought very hard for me to sit my

exams', but that her efforts were ultimately thwarted.

Education Scotland's report records that its review of the records available to it led it to identify issues regarding attainment during the relevant period in the majority of the 39 establishments, albeit that in more recent times there were fewer recorded issues with attainment.

As in previous phases of the Inquiry's work, applicants gave evidence that they did not speak up to report abuse because there were no mechanisms for them to do so, or because, for good reason, they had no confidence that they would be believed. In many cases adults in and outside of the institution were aware of abuse perpetrated by others, and turned a blind eye.

The abuse suffered by children in these institutions had profound and long-lasting effects on their physical and mental health and on their capacity to make their way in the world after leaving care. Many self-harmed and tried to take their own lives, and in some cases succeeded.

As in earlier stages of this Inquiry, the Scottish Government acknowledges the courage of all the individuals who gave evidence about their experiences, and about the impact of childhood abuse on their future lives, and records its gratitude to them for

contributing to the Inquiry.

My Lady, that takes me to the issue of apology, and the Scottish Government wishes to reiterate the apologies already given by it in relation to this phase of the Inquiry's work, and wishes those apologies to stand as part of the Inquiry's record of the submissions made at the conclusion of this phase.

As noted in the interim closing submissions, the written report to the Inquiry by the Scottish Prison Service contains apologies for the abuse that was identified in the research done to prepare that report.

In oral evidence to the Inquiry on 2 November 2023, Teresa Medhurst, Chief Executive of SPS, apologised on behalf of the Scottish Prison Service to the children who were abused when in the care of the SPS and its predecessors, and to the families of those children. She also recognised, accepted and apologised for the impact of that abuse on the physical, emotional and psychological well-being of the children who were abused, both during and long after their departure from prison custody.

When giving evidence on behalf of Education Scotland on 28 September 2023, Janie McManus apologised to children and their families for failings in inspection regimes that contributed to the creation of environments

that enabled the abuse of children to take place.

Neil Rennick in his oral evidence endorsed on behalf of the Scottish Government the apologies that had been given by Ms Medhurst and Ms McManus. He acknowledged that the harm experienced by children in prison settings did not exist in isolation from the operation of the wider justice system and the decisions taken by government and policies set by ministers.

He apologised for the contribution that government decisions and the actions of officials made to the abuse experienced by children accommodated in prisons and YOI settings.

When they gave further evidence on 15 December 2023, Ms Medhurst and Mr Rennick reflected on the evidence that had been given by applicants and made it clear that they wished to emphasise that their apologies extended to the individual survivors who gave evidence, as well as to survivors who for whatever reason have not, or have not yet, given evidence to the Inquiry.

Ms McManus was not recalled, but would want her apology to be understood in the same terms.

LADY SMITH: Thank you.

MS O'NEILL: My Lady, I now turn to the fatal accident inquiry into the deaths of Katie Allan and William Lindsay. The Inquiry will be aware of the

publication on 17 January this year of Sheriff Simon Collins's determination in relation to the deaths of Katie Allan and William Lindsay.

LADY SMITH: Yes.

MS O'NEILL: The Inquiry has in the past asked questions of me about this matter, and, indeed, of witnesses for the Government.

LADY SMITH: Yes.

MS O'NEILL: The Scottish Government has made statements in Parliament and direct to the families of Ms Allan and Mr Lindsay in response to the sheriff's findings.

On 17 January, the Cabinet Secretary for Justice made the statement as follows:

'My deepest sympathies and condolences are with the families of Katie Allan and William Lindsay, who have lost a child and sibling. I am deeply sorry about their deaths and that their families have had to wait so long for the conclusion of this process. I fully appreciate that this has been an arduous process and will have compounded the trauma and distress of the families. Deaths from suicide in custody are as tragic as they are preventable, and the deaths of these two young people should not have happened while they were in the care of the state.'

That was followed, my Lady, on 23 January by

a statement in the Scottish Parliament. Again the Cabinet Secretary stated that the deaths of Katie Allan and William Lindsay were preventable and should not have happened while they were in the care of the state. She also said that the Scottish Government accepted Sheriff Collins's findings that there were systemic failures contributing to the deaths and that the Government accepted the 25 recommendations made by Sheriff Collins and would address in detail each of those recommendations in the Scottish Government's full and formal response to the determination.

My Lady, I should say that that full and formal response remains under construction. The Government has a period of eight weeks from the publication of the determination in which to provide that, but the Cabinet Secretary will report to Parliament again at that stage.

On 23 January, the Cabinet Secretary announced six specific measures in relation to deaths in custody, some of which go beyond meeting recommendations made by Sheriff Collins, as follows:

First, that SPS would urgently and immediately review and revise its policy on items that could be used as ligatures. It will develop an anti-ligature risk assessment and development of suicide prevention technology will be accelerated and, if viable, piloted

and reviewed.

Second, the SPS suicide prevention strategy Talk to Me will be completely revised and overhauled and the Scottish Government, SPS, NHS and the Scottish courts will work urgently and immediately to ensure that all of the written information and documentation available to the court is passed to SPS at the time of a person's admission to prison and a standardised approach to sharing relevant information from agencies will be developed.

Third, the current form of independent sharing of deaths in prison learning and audit reviews will be extended to all deaths in custody with immediate effect.

Fourth, primary legislation will be introduced to make legal aid available on a non-means tested basis to families involved in death in custody FAIs and proposals in relation to family advocacy and support outside the FAI process will also be brought forward.

Fifth, there will be a focused, independent review of the FAI system looking at the efficiency, effectiveness and trauma-informed nature of investigations into deaths in prison custody and the Cabinet Secretary will ask the Chair of that review to report by the end of this year.

Sixth, the Scottish Government will pursue with the

UK Government the lifting of the Crown's current immunity from prosecution, which applies to SPS as a corporate body regarding offences under the Health and Safety at Work Act 1974 in relation to deaths in custody.

His Majesty's Chief Inspector of Prisons for Scotland is to provide oversight and monitoring of the implementation of the actions taken as a result of the sheriff's determination, reporting directly to the Cabinet Secretary.

Further, separate independent national oversight proposals to strengthen accountability in relation to FAI recommendations and to ensure thematic and systematic issues are identified and addressed will be announced later this spring.

LADY SMITH: Thank you.

MS O'NEILL: My Lady, I turn then to secure care.

In relation to secure care, the Scottish Government submitted to the Inquiry in March last year a detailed draft paper describing the routes by which children may come to be accommodated in secure accommodation in Scotland and the frameworks, policies and practices through which they are supported, safeguarded and protected from harm. The Government would simply ask the Inquiry to have regard to the whole of that paper.

LADY SMITH: Thank you.
MS O'NEILL: The interim submissions made in December 2023 included submissions about the Children (Care and Justice) (Scotland) Bill, and in particular about the provisions of the Bill relating to the prohibition of the detention of children in prison and young offenders' institutions. Those submissions referred to the evidence given by Neil Rennick in November and December 2023.

I will come back, my Lady, to the passing of that Bill and its commencement --

LADY SMITH: Yes, thank you.
MS O'NEILL: -- but, my Lady, the submissions in the evidence that were made in the latter part of 2023 referred to work that was being undertaken to ensure that future care services were fit to meet the needs of all children who would require care under the new regime. What follows is not a repeat of that, but an update --

LADY SMITH: Thank you.
MS O'NEILL: -- following those interim submissions.

The key provisions of what is now the Children (Care and Justice) (Scotland) Act 2024 are summarised later in the submissions, but the provisions of the 2024 Act, which involved the prohibition against detaining

children in prisons and young offenders' institutions, were commenced on 28 August 2024.

My Lady, I think there was a question about commencement generally.

LADY SMITH: Yes.

MS O'NEILL: My Lady, there is a commencement regulation or set of regulations. I will give the Inquiry the reference for the record. It is SSI 2024/211.

LADY SMITH: Thank you.

MS O'NEILL: My Lady, that provision came into force -- as a number of others did -- on 28 August last year.

LADY SMITH: Thank you.

MS O'NEILL: The commencement regulations also included transitional provisions to include that children who were under 18 on 28 August would transfer to more appropriate settings before 31 August, so within a three-day period. Substantial preparation and planning were put in place in relation to that process.

The five children who were accommodated in young offenders' institutions on 28 August transferred to secure accommodation during the subsequent two days. The preparations included fortnightly planning meetings on processes and readiness across the sector, and case-specific preparations to ensure appropriate matching of each child to the most suitable placement to

meet their needs.

It also included engagement with secure accommodation service providers, SPS, the Scottish Courts and Tribunals Service, Police Scotland, Crown Office and Procurator Fiscal Service and Social Work Scotland.

My Lady, there is reference in paragraph 6.8 to information sessions delivered across the sector to help prepare the sector for this change, and to a briefing paper developed by Scottish Government officials, and the Children and Young People's Centre for Justice to raise awareness and understanding among partners across Scotland to ensure readiness for the changes.

The 2024 Act also made changes to ensure that where a child is detained in secure accommodation under certain provisions of the Criminal Procedure (Scotland) Act 1995, the child will be treated as a child looked after by the local authority for the purposes of section 17 of the Children (Scotland) Act 1995 and it empowers the Scottish Ministers to make further regulations to ensure that in specific circumstances, young people can remain in secure accommodation up to their 19th birthday.

My Lady, paragraph 6.10 deals with the concerns that the Scottish Government knows has been raised about the

accommodation in the secure accommodation of children who have offended alongside children who have not.

LADY SMITH: Yes, mm-hm.

MS O'NEILL: My Lady, that concern is addressed in detail in the paper on secure accommodation. I include a summary in paragraph 6.10 of the written submission. I was not proposing, my Lady, to read that out. The Scottish Government's position is that mandatory segregation of those children by reference to the route by which they come into secure care is not necessary and is not appropriate.

That view, my Lady, is based on the work described in the written submission, including views taken from children in secure care themselves. My Lady, I can speak to that in further detail if your Ladyship would wish me to, but the material is in the written submission.

LADY SMITH: Can you, just for the record, say high level; why not required?

MS O'NEILL: My Lady, the Scottish Government's position is that its view on this matter reflects research that the needs and experiences of children in young offenders' institutions and those in secure accommodation are extremely similar. The needs of the children, regardless of the route by which they come in to secure

care, will be very similar.

My Lady, that reflects research from England that considered the perception and concern that the risks posed to staff and young people by children in secure accommodation relates directly to the reasons for the child's placement or the nature or gravity of any offence that led to their being placed in secure accommodation.

My Lady, there was also a review, and this is referenced at 6.10.5 of the submission, carried out by the Care Inspectorate between July 2022 and July 2023, which found that most, albeit not all, young people felt safe when living in secure accommodation and the interim report of the Reimagining Secure Care project recorded that no child involved in the project had expressed feeling unsafe or had any concerns relating to a potential increase in the number of 16- and 17-year olds being placed in secure care.

My Lady, there are, of course, measures taken to ensure the protection of all children and staff in secure settings. So, for example, my Lady, 6.10.6 refers to the physical layout of secure centres that can allow for the distancing of particular children from other individuals or from groups, where that is necessary, to prevent harm.

The Scottish Government acknowledges that an increase in numbers of older children in secure accommodation may require adaptations to centres to support those additional demands, and consideration has been given to specialist supports and protections required for some particular children by reference to their needs, for example children convicted of sexual offences or, for example, unaccompanied asylum-seeking children, in respect of whom I understand particular measures have been put in place.

LADY SMITH: I suppose -- I don't know if I am right about this -- it might also be said that whilst there is a need to be acutely aware of the build up between children of tension if you have groups of children who come from different areas. We have heard evidence about that. Within those groups, there may be a mix of children in secure care who are there with the different backgrounds, the welfare backgrounds and the offending backgrounds, but the prime need is to think about whether you need to separate the children in those two groups, if the groups are going to be looked after.

MS O'NEILL: Indeed so, my Lady, but there may be children in both groups with very, very similar needs and behaviours, responding to their welfare needs or their offending background.

LADY SMITH: Is it saying that, well, it is wrong to assume that the child who has an offending background will be a bad influence on the child who is in secure care, because of a care and protection need?

MS O'NEILL: My Lady, I think that is the underlying philosophy. I think it responds in part, my Lady, to an underlying philosophy in connection with some who have expressed the concern that it is in some way unfair to place children with a welfare background with those with an offending background, or that it somehow stigmatises the former by association with the latter.

I think, my Lady, the Scottish Government would reject that philosophy.

LADY SMITH: They would nonetheless have to accept -- I have heard quite a lot of evidence of it being a problem in the history that I have heard over the decades and that children placed for care and protection being placed alongside children with an offending background was a problem and it was harmful to the ones who were there for care and protection.

MS O'NEILL: My Lady, perhaps my attempts to cut short my repeat of the written submission has been less helpful than helpful, because the written submission does make reference to the fact that this issue arose during the passage of the 2024 Act, that amendments were proposed

that would have resulted in a different outcome but were ultimately not pressed. What we have referenced in the written submission is the material that the Scottish Government provided to the Parliament at that time in response to those amendments and that's available to the Inquiry as well as background to the Scottish Government's reasoning on this point, so it is there.

LADY SMITH: Thank you.

MS O'NEILL: My Lady, I had attempted to move quickly over that section, really to get to the question of capacity --

LADY SMITH: Yes.

MS O'NEILL: -- in secure accommodation, because I am conscious that this has been an issue that has been raised in closing submissions this week.

LADY SMITH: Yes.

MS O'NEILL: My Lady, the paper on secure care that the Inquiry has dealt with the issue of capacity in the sector, and described the steps taken by Scottish Government to support increased capacity. I am aware, my Lady, of, I think, concerns expressed by your Ladyship this week about the potential need for the state to intervene if, for example, the private or third sector were to fail in this context.

What I would say, my Lady, is that the steps I am

going to describe having been taken do represent intervention by the state. Not to the extent of taking over the services, but clearly that would have to be something that would be in Government's mind if they did fail. I simply make the submission that the Scottish Government is aware of the issue of capacity concerns and has taken various steps to try to address those concerns.

For example, my Lady, at 6.12, Scottish Government has funded what's described as vacant beds in secure accommodation services. In 2023, there was a pilot project to pay for a place in each of the four secure accommodation centres during, if you like, the absence period after a child had left before another child had arrived --

LADY SMITH: Yes.

MS O'NEILL: -- Scottish Government would pay for that vacant space. The purpose was to ensure vacant secure care capacity for children living in Scotland when it was needed, but also to provide financial support to the centres as discussions began around the future of secure care and to assess the impact and viability of extending or expanding national funding to meet longer-term changes.

That trial was extended through to 31 March last

year, and that went up from one to four places in each secure accommodation centre. Further investment for up to 16 places was agreed for the current financial year, so the Government continues to pay for that vacant space, and the investment in that standing availability is intended to provide some financial stability to the secure accommodation centres, and ensure capacity across the estate for the increase in under 18s being detained in that accommodation.

Scottish Government also has paid for remand placements in secure care, beginning with the commencement of the 2024 Act until the end of the current financial year, that having previously been paid for by local authorities.

It is acknowledged, my Lady, that capacity will continue to be an issue that needs attention. A statement was made on this issue on 8 January of this year by the Minister for Children, Young People and The Promise which acknowledged pressure on secure accommodation places and acknowledged that that had been compounded by the temporary suspension of new admissions to St Mary's Kenmure.

The statement summarised the steps already taken by Scottish Government, including the support for contingency resource described above, and ongoing work

in relation to secure capacity. That includes working with secure care providers and others to establish agreement on the minimum vacant secure capacity that's needed for Scotland overall at any given time and exploring the establishment of a new national contingency resource.

Finally, my Lady, reference is made to the National Secure Adolescent Inpatient Service for Scotland. That's a facility that is, if you like, a state facility, it will be hosted by the NHS, and will be a secure mental health inpatient facility providing services to children between 12- and 18-years old who have mental health issues.

LADY SMITH: Thank you.

MS O'NEILL: My Lady, on the quality of secure care clearly, my Lady, the Scottish Government wishes to ensure that all children who are placed in secure care receive the highest quality service. The Government acknowledges that that has not always been the case, and the recent interventions at St Mary's are evidence of that.

Now, my Lady, the Care Inspectorate has already discussed what has happened in relation to St Mary's. I have said that at one level these interventions can be seen as representing the effective operation of the inspection and monitoring regime. Clearly the

inadequacies ought not to have occurred and were not welcome. But the Care Inspectorate intervention did pick up significant concerns in relation to children and young people's health, welfare and safety needs and there was regulatory action taken in response to the inspection findings.

My Lady, I would simply mention that so far as Scottish Government is concerned, children who are at St Mary's who have been placed there by Scottish Government in the sense that Scottish Government remains responsible for their care, those children are the subject of ongoing discussions between Scottish Government officials and St Mary's, with officials being given regular updates on what is happening at St Mary's.

My Lady, the next section is on potential future reform of secure care. The Reimagining Secure Care project issued its final report on 27 September, again last year, alongside a children and young people participation report and a literature review.

As well as considering changes that might need to be made to respond to new measures to accommodate children in secure care who would otherwise have been in young offenders' institutions, the project also looked at options for more radical transformation of secure accommodation. The background to that work, my Lady, is

described in the secure care paper submitted to the Inquiry and in the interim closing submissions delivered in December 2023. The key recommendations are summarised -- my Lady, clearly they are summarised in quite short order in these submissions --

LADY SMITH: Yes.

MS O'NEILL: -- but they include creation of community-based hubs to offer support tailored to local needs across different areas, including education, training, health and leisure. There is a proposal for the use of multidisciplinary teams to provide specialised support to children and their families, and to ensure continuity and integration across services, and there is a proposal for the creation of a service described as 'flex secure', which would involve intensive 24/7 care for children in home-like environments that are embedded in their communities. These are intended to be offering adaptable levels of security, reflecting children's individual needs and potential harms, and allowing the opportunity for families to visit and potentially stay overnight with those children.

The philosophy there, my Lady, is to support the use of the minimum level of restriction required to ensure the safety of the child, and others as necessary.

My Lady, that report is under consideration by

Scottish Government with COSLA and Social Work Scotland and it is anticipated that plans for change should be available again in the spring and if the Inquiry would wish an update in due course, that can be provided.

LADY SMITH: Thank you.

MS O'NEILL: My Lady, restraint is also a key issue in this phase of the Inquiry's work, and many applicants gave evidence about the inappropriate, violent and abusive use of restraint across the decades.

A number of factors contributed to an environment in which abusive restraint practices were able to flourish. As was spoken to by Professor Norrie, there was, until this century, no specific regulation of restraint within residential care settings for children.

In addition, while applicant evidence suggested that abusive restraint practices were motivated in many cases by sadism or a desire to inflict cruelty, there was also clear evidence that an absence of adequate training for staff involved in restraint was also a significant factor, and that historically there was an absence of consensus on the appropriate approach to restraint. That, of course, already had been noted in the Kerelaw report.

While training did eventually become mandatory in particular institutions, enforcement of that mandatory

requirement was not consistent. Again reference is made to the Kerelaw report.

The current regulatory framework which applies to the use of restraint in residential care settings is set out at paragraph 7.7 of the written submission. The statutory provisions sit alongside the Holding Safely guidance that was first introduced in 2005, and updated in 2013 and 2014. That guidance also sits alongside standard 30 of the Secure Pathway and Standards which provides:

'I am well supported to manage my feelings and [so] I am only ever restrained when this is absolutely necessary to prevent harm. I am treated with respect, dignity and compassion and I am held in the least restrictive way for the shortest time possible. I am well supported afterwards.'

The guidance applicable to residential care environments has also been added to by new guidance on physical intervention in schools issued by the Scottish Government at the end of last year.

Holding Safely is acknowledged to be ten years old in terms of its last update and it will be considered as part of ongoing work with CELCIS and the University of Strathclyde to develop an alternative approach to requiring restraint which is embedded in relational and

reflective practice.

The Scottish Government is very well aware that the Inquiry has heard evidence throughout its work that the existence of statutory regulation and non-statutory guidance is not sufficient to ensure the protection of children and that children have been failed because compliance with regulatory regimes has not been monitored or enforced.

So far as monitoring and enforcement in relation to restraint is concerned, the written submission points to a number of mechanisms.

The first is the responsibility of the Care Inspectorate for monitoring the use of restraint and the measures introduced by it to improve data collection and consistency around the reporting of restraint and restrictive practices. This was a strand of work undertaken specifically in response to The Promise. The Care Inspectorate also published a restricted practices self-evaluation tool to support practitioners and services to evaluate progress to reduce those practices and identify further areas of improvement.

The Inquiry has heard evidence from the Care Inspectorate about its approach to record keeping and inspection relating to restraint. There are contractual requirements imposed on providers of secure

accommodation under a Scotland Excel framework, including obligations to put in place appropriate policies and procedures, and inspections also address restraint practices. Reference is made to the Education Scotland report of Edinburgh Secure Services in September 2022, finding that there was insufficient information about physical intervention and restraint.

My Lady, The Promise concluded that Scotland must strive to become a nation that does not restrain its children. The Scottish Government is aware that success has been achieved in some areas and services through adopting models which have transformed practice by not requiring or by reducing the use of restraint and/or restrictive practice.

My Lady, we are aware of the evidence given by Aberdeen City Council on that issue. Scottish Government has discussed the council's approach with it in the context of wider discussions about residential care services, and is also in the process of meeting with representatives of local authorities across Scotland on the issue of best practice in reducing restrictive practice.

The Scottish Government considers that it is unlikely to be possible to eliminate restraint entirely, that situations will continue to arise where restraint

is necessary to protect the safety of the person being restrained and/or others, but it is clear that the use of restraint should always be a last resort, in exceptional circumstances, when it is the only practicable means of securing the welfare or safety of the child or other person.

Through The Promise Partnership Fund, the Government has supported pilot projects focusing on the development of relationship-based and reflective practice, and it also participates in the work of the Scottish Physical Restraint Action Group and Restraint Reduction Scotland, both of which are concerned with restraint reduction in a range of settings.

Then, my Lady, reference is made to SPS and the piloting of pain-free restraint techniques in SPS, which continues to be ongoing, not withstanding that of course children are no longer accommodated in the prison estate.

LADY SMITH: Yes, good.

MS O'NEILL: My Lady, in relation to segregation and isolation, again abusive practices featured in the evidence of many applicants and those could be particularly severe in young offenders' institutions, isolation being used as a punishment in response to children who reported abuse on many occasions.

The Scottish Government's view is that the use of restrictive practices including seclusion should always be a last resort and used only in exceptional circumstances, when it is the only practicable means of securing the welfare or safety of the child or another person, and that seclusion should be for the shortest possible time.

The Promise clearly also was concerned with isolation and segregation, and I have quoted from its report and conclusions which are accepted, and supported, by Scottish Government. There is currently no formal Scottish Government guidance specifically concerned with seclusion in residential childcare settings, and it is not explicitly covered by the Holding Safely guidance. However, since that guidance was published, the working definitions of 'restrictive practices' have evolved and specific definitions on 'seclusion' are contained in the Care Inspectorate's restrictive practice self-evaluation tool and also in guidance to registered care services for children and young people on record keeping and notification.

Health and Social Care Standards also provide that restrictions on an individual's independence, control and choice must comply with the law, be justified, be kept to a minimum and be carried out sensitively, and

that the individual should be as involved as they can be in agreeing and reviewing such restrictions.

In November 2023, a number of organisations wrote to the Scottish Ministers to call for a holistic, human rights' based statutory guidance on restraint and seclusion. They requested that that be based on a consistent legal framework that applies to all situations where children are in the care of the state, including schools, residential and secure care and mental health provision.

The Scottish Government's position is that an overarching piece of legislation across all settings is not necessarily the most effective means to achieving the reduction or eradication of restraint and seclusion, and that an approach that takes account of the specific setting is more appropriate, and that each sector should ensure that there is adequate support, training, guidance and reporting to meet the needs of the children in that sector. The Scottish Government is committed to working with key partners in the children's residential child care sector to further reduce and, where possible, eliminate the use of restraint and seclusion, and is working with CELCIS and the University of Strathclyde to develop a project on reducing the use of restraint by developing training and tools necessary for that sector.

LADY SMITH: Is Scottish Government's thinking at the moment that the way forward to address the problem of inappropriate and abusive use of isolation and segregation is not to legislate, but to engage with each sector separately?

MS O'NEILL: It is certainly not to legislate for all sectors across the board in a uniform way, my Lady --

LADY SMITH: Right.

MS O'NEILL: -- I don't understand there to be any specific legislative proposal at all for any sector, but that the focus is on training, support and guidance rather than legislation, and on a sector-specific basis.

LADY SMITH: I am not suggesting there should be legislation, I am just trying to understand where they are going at the moment, because --

MS O'NEILL: Certainly, my Lady, there is no legislative proposal on restraint at present.

LADY SMITH: Thank you.

MS O'NEILL: My Lady, the next section of the submission is on peer-on-peer abuse and unwanted sexual behaviour. Again, my Lady, the Inquiry has heard substantial evidence about this type of abuse and reference to it is made in the written submission and to the conditions which allowed it to happen. At paragraph 9.5, the submission refers to the Inquiry's framework document,

which referred in the context of peer-on-peer abuse to the report of the expert group for the Scottish Government on harmful sexual behaviour published in 2020. The framework document records that the report had been criticised as being superficial, as tending to treat harmful sexual behaviour as a single phenomenon, and to treat children engaged in such behaviour as a homogeneous block.

The Scottish Government is conscious that there hasn't been evidence from it specifically on this issue and I am conscious that closing submissions are not a substitute for evidence. I would, however, make the Inquiry aware of work that has been done in consequence of the 2020 report. To ensure that the report's recommendations were implemented effectively, the Scottish Government's Child Protection Unit set up the Harmful Sexual Behaviour Delivery Group -- which has representation from across a number of sectors -- in December 2020.

That group established three work streams: support for education, in particular professional learning, including the formation of a national network of child protection education leads in local authorities; assessment and intervention, including the development of a resource for front line practitioners; and delivery

of and shared learning from a pilot programme across three child protection committees to implement the NSPCC HSB audit tool, and, my Lady, that, I understand, to be a tool which assists practitioners in identifying harmful sexual behaviour.

Outcomes from the work that was done include those listed at paragraph 9.8 of the written submission, including the development of guidance for staff in education and training settings, a survey to seek the views of children and young people on harmful sexual behaviour, research by Stop It Now Scotland, and the roll out of training by that organisation, which was funded by Education Scotland, to help schools tackle online problematic sexual behaviours, inclusion of a child displaying HSB as a vulnerability factor or a concern at child protection registration within the revised minimum data set for collection by child protection committees, and the publication of a page on harmful sexual behaviour on the Parent Club website.

My Lady, as far as the report's specific recommendations have been concerned, work has been done on all of those, and a couple are mentioned, my Lady, at paragraphs 9.10 and 9.11 of the written submission.

My Lady, I have a couple more sections of the submission to deal with --

LADY SMITH: Yes.
MS O'NEILL: -- I am happy to continue or to rise as your Ladyship prefers.
LADY SMITH: I think we should break now and return to your submissions at 2 o'clock, please, Ms O'Neill.
(1.00 pm)
(The luncheon adjournment)
(2.00 pm)
LADY SMITH: Welcome back.
Ms O'Neill, when you are ready.
MS O'NEILL: Thank you, my Lady, I think I have managed to just about clear the room.
LADY SMITH: I am sure everybody is listening from elsewhere, they wouldn't want to miss a word of it.
MS O'NEILL: There are a couple of chapters at the end of the submission on legislative reform and other reform.
LADY SMITH: Yes.
MS O'NEILL: Chapter 10 is on the Children (Care and Justice) (Scotland) Act 2024, I have already made reference to the Act --
LADY SMITH: Yes.
MS O'NEILL: -- and the Inquiry has obviously heard evidence already from Scottish Government witnesses, and has both written and oral submissions from me earlier in this phase in relation to what was then the Bill.

The overarching policy objectives of what is now the 2024 Act are to improve experiences and promote and advance outcomes for children, particularly those who come into contact with care and justice services. The Bill's provisions aim to increase safeguards and support, especially to those who may need legal measures to secure their well-being and safety and the Act is intended to reflect the Scottish Parliament and Scottish Government's commitment to embedding the principles of the United Nation's Convention on the Rights of the Child.

LADY SMITH: Yes.

MS O'NEILL: Once fully commenced, the Act will make a range of changes to the law relating to, among other things: children's hearings; the treatment of children by the criminal justice system, including detention following conviction; residential and secure care; and anti-social behaviour disorders.

My Lady, I gave you the reference for the first commencement order --

LADY SMITH: Yes.

MS O'NEILL: -- that has been made in respect of the Act. That does not commence all of the provisions of the Act, but it did commence the provisions relating to children in custody.

Of particular relevance to this phase of the Inquiry's work, the Act expressly prohibits Scottish Ministers from directing that a child be detained in a prison or young offenders' institution and abolishes remand centres. That is one of a number of provisions serving the aim of ensuring that where a child who is in conflict with the law requires to be deprived of their liberty, that this occurs in age and stage-appropriate environments that are therapeutic and allow the child to benefit from intensive care and support, and, as mentioned before, those provisions came into force on 28 August last year and the five children then accommodated in YOIs were transferred to secure accommodation.

LADY SMITH: Yes.

MS O'NEILL: A child who is detained in secure accommodation is to be treated as a child who is looked after by the relevant local authority for the purposes of the Children (Scotland) Act 1995, and that provision also came into force on 28 August, and so is already in force.

LADY SMITH: The significance of that is that the responsibility is then passed over to social work.

MS O'NEILL: Yes, and there is someone, my Lady, with statutory responsibility for that young person.

LADY SMITH: Yes.

MS O'NEILL: The Act also introduces an updated statutory definition of 'secure accommodation service', which makes clear:

'Such a service provides accommodation in a residential establishment for the purpose of depriving children of their liberty, but also provides appropriate care, education and support for the purposes of safeguarding and promoting the welfare of the children who are accommodated there, and takes account of the effects of trauma which the children may have experienced.'

That is one of a number of provisions imposing obligations on decision makers to take account of the trauma experienced by children, and which seeks to avoid or minimise the risk of additional trauma.

There is a power for Scottish Ministers to make regulations in relation to the approval of secure accommodation services, and there are new provisions in relation to the emergency placement of children, in particular prohibiting removal to a place of safety that is secure accommodation unless one of a number of pre-conditions are met.

Those being, again in summary: that the child has previously absconded, is likely to do so, and in doing

so it is likely that the child's health, safety or development would be at risk; or that the child is likely to self-harm unless they are kept in secure accommodation; or that the child is likely to cause physical or psychological harm to another person unless the child is kept in secure accommodation.

LADY SMITH: Yes. Am I right in thinking -- I am sorry, I should have checked this -- if the removal is to a place of safety, then the requirements kick in about reviewing the child's circumstances in early course?

MS O'NEILL: My Lady, I think that's correct. I don't want to mislead your Ladyship, I can't say for certain that I am as familiar with the legislation as your Ladyship is. I am also not certain about that provision yet being in force. But I will just try to double check now before I conclude.

LADY SMITH: Without worrying about the detail, my point rather is it seems obvious that if you are making provision which sensibly allows for there still being a requirement for emergency placement, whilst it is important to provide, you can't do that unless those three criteria are met.

MS O'NEILL: Indeed.

LADY SMITH: Equally, you can't just do it and forget about the child, so early review of what's going to happen to

the child next must be of critical importance.

MS O'NEILL: I think, my Lady, the regime for that, which existed previously --

LADY SMITH: That's what I am thinking.

MS O'NEILL: -- remains in place, but let us check and confirm.

LADY SMITH: It may be as simple as making sure that it does because since, oh, decades back when we first had the secure emergency removal of children to places of safety, it was in place then. I hope I am right in thinking that that hasn't been let out of the bath with the bathwater by mistake.

MS O'NEILL: My Lady, there is just one point to finish on in terms of the 2024 Act, because I think a question may have been asked earlier this week about whether the change in definition of a child to an under 18-year old has come in to force.

LADY SMITH: Yes.

MS O'NEILL: That has come into force, but in connection with the detention and custody provisions. It is also going to come into force in relation to referrals to children's hearings, but that is not yet in force.

LADY SMITH: Yes, I think that was it and it was also being referred to in the context of the ability to make continuing provision for the young person, the teenager.

The 17 to 18 --

MS O'NEILL: Yes.

LADY SMITH: -- and 18 until the child is 19 period.

MS O'NEILL: I don't think that is yet in force, my Lady.

LADY SMITH: Right, thank you.

MS O'NEILL: My Lady, I was then going to move on to reform in the area of inspection of education services.

LADY SMITH: Yes.

MS O'NEILL: Again, the Inquiry has evidence in writing and orally from Education Scotland in relation to historic and current inspection regimes. Again, that evidence isn't repeated here.

By way of update, my Lady, the commitment to deliver at least 250 school inspections each year has been met since inspections began again in September 2022, after the Covid-19 pause.

In the academic year 2022/2023 there were 253 school inspections.

In the following academic year, 256 school inspections were carried out.

Education services are delivered in 24 residential and secure accommodation establishments, and 12 of those 24 have been inspected since 2020.

My Lady, on proposals for legislative reform of the education inspection regime, at the time of the interim

closing submissions in December 2023, there was then noted that a consultation exercise had begun on the proposed education reform bill and that the Scottish Government had accepted in principle recommendations made by Professor Kenneth Muir that a new inspectorate body should be established, with its independence enshrined in legislation and with governance that reflected that independence.

At that stage, my Lady, no bill was before Parliament, there was only a consultation exercise. The Bill, the Education (Scotland) Bill, was introduced in the Scottish Parliament on 4 June last year. The stage 1 debate on the Bill took place on 18 December last year, when the Scottish Parliament approved the general principles of the Bill and the Bill is currently at stage 2 of its parliamentary consideration.

Part 2 of the Bill makes provision for the creation of the office of His Majesty's Chief Inspector of Education in Scotland and the appointment of a deputy chief inspector and inspectors of education in Scotland.

Under the Bill's provisions, if passed, the Chief Inspector will have a statutory duty to secure the inspection of relevant educational establishments at such intervals and to such an extent as the Chief Inspector considers appropriate. But that is subject to

any requirements imposed by Scottish Ministers in regulations.

The Scottish Ministers will also be empowered to require the Chief Inspector to inspect a relevant educational establishment, a type of establishment, or a sample of a type of establishment. Notwithstanding, my Lady, these powers to require inspections or to make provision about the frequency of inspections, the Bill makes specific provision to protect the Chief Inspector's independence. Paragraph 2.1 of schedule 2 to the Bill provides:

'Subject to any contrary statutory provision, in performing the Chief Inspector's functions, the Chief Inspector is not subject to the direction or control of any member of the Scottish Government.'

The Scottish Government's view is that the Bill's provisions align with the recommendations of Professor Muir as to the independence of the inspectorate and represent a significant change from the current structure of housing the inspection function within Education Scotland. The stated aim is to increase public confidence in the independence of inspection and the capacity of the Inspectorate to assess and identify strengths and weaknesses across the education system.

My Lady, the Bill will also confer quite wide-ranging powers on inspectors, for example to enter establishments, will impose duties on managers of educational establishments to provide assistance to inspectors and provide for offences, my Lady, if there is a failure to do so.

LADY SMITH: Thank you.

MS O'NEILL: It is anticipated that the Bill will complete its passage through Parliament this summer, but obviously that is a matter for the Scottish Parliament.

My Lady, the last chapter of the written submission is on independent review of inspection, scrutiny and regulation. Amongst all the many things about which submissions were made previously, the Inquiry may recall submissions being made to an independent review of inspection, scrutiny and regulation of social care in Scotland, established in September 2022.

That reported in September 2023, and made 38 high-level recommendations. They were accepted by Scottish Government on 6 March last year.

I think the thing to note, my Lady, is that these are broad in compass and they don't all relate to inspection practices. Some of them do, but work is ongoing in different areas to give effect to a number of the recommendations. I have given some examples.

For example, recommendation 19 was that inspectors and regulators, while fulfilling their statutory duty to identify shortcomings in improvement, should also place equal weight on identifying good practice, innovation, and improvement across the sector.

In response to that recommendation, a draft Scottish learning and improvement framework for adult social care, support and community health has been co-produced by a cross-sector group and is expected to be published this year. That's intended to help move from a predominant focus on scrutiny and measuring performance to an approach which builds improvement and quality management into the system.

My Lady, I acknowledge that that's an adult social care response --

LADY SMITH: Yes.

MS O'NEILL: -- and again the review was not directed at children's social care specifically, it was looking at social care across the board.

My Lady, there are other examples in the submission. 12.2.4 relates to Recommendation 13, that the Social Care and Social Work Improvement Scotland Requirements for Care Services Regulations 2011 be reviewed to ensure consistent, effective and comprehensive applicability of the fit and proper person provisions across social care

support services in Scotland, and work is ongoing with the Care Inspectorate to identify how that might be done. So as to avoid, my Lady, as I understand it, inconsistent approaches to fit and proper person requirements in different care environments.

LADY SMITH: Yes.

MS O'NEILL: My Lady, an update on implementation of all of the recommendations from that review is due to be published by the Scottish Government in the first quarter of this year.

LADY SMITH: Thank you.

MS O'NEILL: My Lady, that's everything in the written submission. I did want to come back to the question of the level 9 qualification that your Ladyship mentioned --

LADY SMITH: Yes, please.

MS O'NEILL: -- earlier in the day.

I am afraid, my Lady, I am not in a position to give the Inquiry a full update on where that stands. I have asked for that information, but I think it will have to be provided to the Inquiry in writing.

What I am able to advise is that the recommendation that was made was the subject of a consultation exercise in 2017.

LADY SMITH: Yes.

MS O'NEILL: I understand that the pausing of implementation of the recommendation was in part a response at that time to some of the things that had come out of the consultation exercise, so if I can put it in this very broad way, it was not simply that Government took no steps in relation to that recommendation, but rather the consultation responses presented challenges to its implementation. I am being deliberately high level, again, not to mislead the Inquiry because I appreciate it needs proper and full information on this point. The intention is to provide that in writing, just as soon as possible.

LADY SMITH: I am sure you understand why it is raised. 2016/2017 may, on the face of it, sound like not very long ago, but actually it is over seven years ago.

MS O'NEILL: My Lady, the point's well taken and it is well understood that the Inquiry needs to have an update on this issue. I would rather that was done accurately than for me to give your Ladyship incomplete information.

LADY SMITH: Thank you, yes.

Certainly the last we know from SSSC, as I understand it, is that they are still waiting to hear.

MS O'NEILL: My information, my Lady, is slightly different, but again I think it is better that we give your

Ladyship something fuller.

LADY SMITH: If that impression is wrong, please correct us, because it may simply be SSSC have not updated us and we are still left waiting to hear.

MS O'NEILL: My Lady, those are my submissions, unless your Ladyship has other questions for me.

LADY SMITH: Well, more generally, it is this issue of, I am obviously interested in whether Government contributed to systemic failings of the past and I am not clear from what has been said so far whether Government really accept that or not. I know there are places that say we recognise there were system failures, but if you take, for example, this requirement for residential care workers to be qualified, or the List D and approved schools being dependent on grant funding, that they didn't know year on year exactly the amount of and what I have heard from their perspective was that meant they couldn't employ all the staff they needed, and that in turn meant poorer care for children. If they are right about that and that was the grant system and the way it was working, is it accepted by Scottish Government that that meant that they were making a material contribution to circumstances which rendered children vulnerable to abuse?

MS O'NEILL: My Lady, can I answer that question in this

way: I don't have specific instructions on specific failures by reference to the kind of examples your Ladyship gives. Therefore I am hesitant to say anything about those specifics. But by reference to what I did say this morning, it is entirely accepted that throughout the period that the Inquiry is covering, the state failed in a number of respects that contributed to conditions in which abuse took place. My Lady, that is by reference to resources and funding and by reference to delays that there have been in creating a more effective regulatory regime.

I am not in a position to point to a failure on any very specific issue and say that contributed to abuse in this place or that place, but if this is of assistance to the Inquiry, it is certainly not the Government's position that the operators were entirely to blame. The operators were operating within a framework of regulation and resource for which the state had responsibility, and to the extent that the state failed in providing that resource and framework, it contributed to the conditions for abuse.

That's not intended to be a hedging response at all, it is intended to be helpful, but if it is not, my Lady, then please tell me.

LADY SMITH: No, I can see how you can't go any further at

the moment. Of course there lies behind failures in, for example, regulation, or the provision of resources, the matter of policy, for which the state is responsible. If you go back to grants, what's our policy at the moment on actually using the money that is available for making grants to approved schools? As an example. Does that mean that the way things filter through to the people who make the decision on X pounds or Y pounds is that well, you have to be careful, don't spend too much there if you can avoid it.

The same with prisons, when, for a period, children were ending up in prisons, some in very undesirable circumstances, during a period when prisons were being starved of resources as well and there was a knock-on effect to children. It certainly doesn't seem to have been any specific policy for at least trying to make sure that proper resources were allocated to secure children in the best environment possible.

MS O'NEILL: My Lady, where I make reference to failures in relation to regulation and resource, I include policy failure too.

LADY SMITH: Yes, well, that's very helpful.

Thank you very much, Ms O'Neill, I am grateful to you.

Can I just say before I rise for the last time in

Phase 8, I am really grateful to the time, trouble and attention that has been devoted to the work that Phase 8 has required by the 25 institutions and organisations who have had leave to appear. I know that they have had visited upon them, no doubt not always welcome, section 21 notices which have required them to produce thousands of documents, answer many, many questions, to provide us with details, and I don't underestimate the work that has generated. But it is important work, and I am sure nobody would try to gainsay me on that.

You heard early on from Mr MacAulay some facts and figures. What we have achieved in Phase 8, on the face of it, just sounds like a run of numbers; 154 days or so spent in hearings, a total number of 454 applicants, with 133 of them providing oral evidence. Another 101 witnesses giving oral evidence. The timescale ranging for our investigations over our usual 1930 or so up to the end of 2014, and evidence being ingathered, analysed, examined and presented, particularly from the 1960s, 1970s and 1980s, to say this has been an extensive case study is a huge underestimation.

I also want to put it on record how grateful I am for all the Inquiry staff who have worked so hard to make this happen. No statement has been able to be produced in evidence without the hard work of our

statement takers, our witness support team, the lawyers, who diligently work at a number of tasks in relation to the statements and the witnesses, the questions that arise day and daily of a sort that we haven't encountered before and we have to address. The redaction challenges for the redaction teams to help me discharge my section 18 obligations, whilst at the same time having regard to matters such as the General Restriction Order that I have issued. And the counsel, who have worked so hard at studying this work and seeing that it can be presented in the limited time available. It may not sound as though September 2023 to February 2025 is limited time, but for the amount of evidence we gathered it was, and they have worked tirelessly and utterly reliably to see that it could happen.

So my thanks to everyone, and I hope that everyone involved can at the very least take this weekend off.

Thank you.

(2.25 pm)

(The Inquiry adjourned until a date to be decided)

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