Wednesday, 8 October 2025

(10.00 am)

LADY SMITH: Good morning, and welcome to the last day of our evidence in relation to Phase 9 of these case study hearings, the phase in which we've been looking at the provision of residential care for children with healthcare, additional support or disability needs.

Today, we move to evidence beginning with evidence from academia, I think, Ms Innes, is that right?

MS INNES: We do, we have Professor Anita Franklin and Dr Jo Greenaway from Manchester Metropolitan University.

LADY SMITH: Thank you.

Professor Anita Franklin (sworn)

Dr Jo Greenaway (sworn)

LADY SMITH: Do please both sit down and make yourselves comfortable.

Is it also okay if I call you Jo?

DR GREENAWAY: Yes.

LADY SMITH: I'm happy to call you Dr Greenaway if that's better, that's fine by me. Thank you.

Thank you both for coming along this morning, and thank you both for the report that you've provided for us in advance. It's been very helpful to have that and be able to review it before hearing from you today.

I think you know what the plan is. Ms Innes is

going to explore certain aspects of it with you that are particularly relevant to this part of our work that we have been engaging in for some time now and it's very good to have you here, right at the end of it, to help us with some aspects.

You've got copies of the report that you provided to us in the red folders there. If you've got your own notes as well that you want to consult, do feel free to use those. We'll also bring the parts of the report that we're looking at at any particular time up on the big screens in front of you, you may find that helpful, you don't have to use it but it will be there if it is of any use to you.

If at any time you want a break, please let me know. I take a break at about 11.30 am in the mornings in any event, but it's okay to have a break some other time if either of you need it.

PROFESSOR FRANKLIN: Thank you.

LADY SMITH: If you don't have any questions at this stage, I'll hand over to Ms Innes and she'll take it from there, is that okay.

PROFESSOR FRANKLIN: Yep, that's fine, thank you.

LADY SMITH: Thank you.

Questions from Ms Innes

MS INNES: Thank you, my Lady. If we could look first of all at your respective CVs, thank you for providing copies of these to the Inquiry.

Anita, we can see that your current position is as Professor of Childhood Studies at Manchester Metropolitan University. We can see that you gained your PhD in 2010 in Social Policy and Social Work, and that you've worked in research in various organisations as well as universities. And prior to taking up your current position, you were Professor of Childhood Studies at the University of Portsmouth from 2019 up until 2023, is that correct?

PROFESSOR FRANKLIN: Yes.

Q. And you've told us about your specific areas of interest, and you note that your work majored on developing policy and practice change in areas of inclusion and marginalisation, child protection and exploitation of disabled children and young people and concerning disabled children and young people's agency and participation within individual and strategic decision making.

PROFESSOR FRANKLIN: That's correct.

Q. And you've set out a number of academic papers that you have published over the years, and some research studies

that you have taken part in, and some of these include, for example, working together to prevent sexual abuse of children with disabilities and effectiveness of services in responding to abuse from the perspectives of young people with learning difficulties?

PROFESSOR FRANKLIN: That's correct, yes.

Q. Now, Jo, we can see that -- from your CV, that your current role is as Senior Research Associate at Manchester Metropolitan University?

DR GREENAWAY: Yes.

Q. And we can see that you also worked at the University of Portsmouth prior to that as a research associate there as well?

DR GREENAWAY: Yes.

Q. And we can also see from your CV that you gained your PhD in 2020?

DR GREENAWAY: Yes.

Q. And your background includes training as a social worker, and having worked as a social worker with children with disabilities?

DR GREENAWAY: Yes.

Q. Okay.

And again, you've set out some of the academic publications that you've been involved in over the years as well?

DR GREENAWAY: Yes.

Q. Okay.

Now, I wonder if I could ask you, please, to look at LIT-000000393, which is a draft report on the 'abuse in residential care institutions for disabled children and young people'. And we can see that you both worked on this report together with an Alice Leyman?

PROFESSOR FRANKLIN: Yes, that's right.

Q. And is she another member of your team at Manchester Metropolitan University?

PROFESSOR FRANKLIN: She was an associate for the duration of that project, bringing skills around literature searching.

Q. Okay.

LADY SMITH: Anita, we may need just to get that microphone a little bit nearer you.

PROFESSOR FRANKLIN: Is that better? I can talk up. Is that better?

LADY SMITH: I think that's a better angle, yes, thank you.

MS INNES: If we can look on to page 8 of the report, please, we see the introduction and, at the bottom of the page, in the very final sentence there, it says:

'The overall aim of this report is to review the available evidence ...'

So it goes on to page 9:

'... review the available evidence in relation to the abuse of disabled children up to the age of 18 years (including those with long-term health needs and additional support needs) in residential care settings.'

And you note that:

'Few studies have investigated the abuse of disabled children in residential care in Scotland.'

And therefore you looked across the UK and internationally to find any relevant material that would assist us; is that correct?

PROFESSOR FRANKLIN: Yes.

Q. Okay. Do you have any idea why it is that there's such a lack of research on this area in Scotland?

PROFESSOR FRANKLIN: I think, to be fair, it's not just Scotland. I would say, worldwide, there are issues around both the funding available to undertake this research, but actually the quality of data available on which to do research with. So I don't think it's necessarily Scotland per se that doesn't have this research evidence, it's across the board. And that's actually what we found as well, it was very hard to find research that had been undertaken in this specific area, with this specific group of children and young people.

Q. Okay. And if we go on to page 10, we see a bit more about this issue, about lack of data. In the first

paragraph there you note that the number of disabled children living in institutional settings worldwide is not known, largely due to inconsistent definitions of disability and of setting type, and significant gaps in robust and systematic data collection, and reporting. So even before we look at abuse, I think you found that there was a lack of data in relation to disabled children, full stop?

DR GREENAWAY: Absolutely, yeah, yes.

PROFESSOR FRANKLIN: It comes down to definitions, what do we mean by 'disabled child', and I think that's always been the problem with research and with data collection, is definitions around disability as a starting point, but then also on an emphasis placed on collection of data concerning disabled children. So you'll find not just in official statistics, but also within research evidence, that there is inconsistent definitions around disability. There isn't also consistent definitions around what we mean by an institution as well, so we can see that wherever children are placed, and disabled children are placed, they're quite often not recorded or the focus of research, because of these definitional issues.

So it's across the board that that is happening, not just in Scotland, but worldwide, we're seeing problems

with that.

Q. Okay.

And at the bottom of this page, under the heading '1.1', there's reference to child protection statistics in Scotland, and the reasons why children are placed on the child protection register.

The next paragraph says:

'Despite these figures, Scotland lacks comprehensive studies that explore prevalence and patterns of abuse specifically affecting disabled children.'

And then I think you go on from there to talk about material drawn together by the Care Inspectorate from child protection committees.

And if we go on to the top of the next page in the paragraph beginning 'In 2021', you refer to a triennial review of ICRs and SSCRs carried out between 2018 and 2021. Then there's, from what you say here, some of the material does make reference to children having a disability, but in other cases there's no reference to whether a child has a disability or not?

DR GREENAWAY: That's correct.

PROFESSOR FRANKLIN: And I think that's the problem, actually, with how data is cut or used, because that is a prime example of where it's very difficult to collate the data of disabled children, whether they're living in

families or in institutions or even if disability is recorded. So particularly with the triennial review, which was data on the initial case reviews or significant case reviews, it was very hard to pinpoint disabled children, but then also disabled children in institutions. So it's a problem with how the data is managed there, which causes concerns because there's the invisibility then of disabled children within those kinds of collections of data. We need that data disaggregated, but also aggregated in certain ways to be able to identify this particular group of children.

Q. Okay. Yes, you mentioned the issue about settings at the end of the next paragraph, just above the heading 'Abuse of children in care', where there's a sentence where you're referring to, I think, the 2023/2024 Care Inspectorate learning collation of material from learning reviews. And it says there:

'From the little information gleaned from the statistical data, it's not possible to determine whether the harm of a disabled child was as a result of abuse within the residential ... or other care settings such as foster or kinship care.'

PROFESSOR FRANKLIN: That's also another issue that we found with data in general and with research evidence, not just in Scotland, across the world actually, is again

it's -- they would talk about maybe disabled children in care, but again they won't make the differentiation between whether it's in kinship care or foster care, or in a residential setting. So again, there's invisibility of this group of children who are in institutions, and that was particularly the case there with the triennial reviews. But it's also a case across the board in terms of research evidence.

Q. Okay. So to resolve that, I suppose you would be suggesting that disability ought to be recorded in every case, and also the setting in which the abuse occurred?

PROFESSOR FRANKLIN: Yes.

Q. So that it can be properly analysed?

PROFESSOR FRANKLIN: Absolutely.

DR GREENAWAY: Yes.

PROFESSOR FRANKLIN: We need to understand the context for the child, and also so that you can understand the context of their needs being met within the context of the setting that they're in, and I think that's the challenge with the data. When it's separated out like this, you can't identify the specific needs of that child in that setting but also, of course, where and if abuse has occurred.

DR GREENAWAY: Yes, I would concur with that.

Q. Okay.

Now, if we look down to the heading '1.1', you refer to a report prepared for the Inquiry by Radford and others in 2017. And you note, in the second part of this paragraph, that the review emphasised issues concerning accuracy and prevalence of historical records of abuse in the care system and the lack of Scottish specific data of self-reported abuse.

However, particularly in the context that we're looking at here, you note that challenges of accessibility for disabled children and of disabled adult survivors to self-report abuse may present an underreporting by this group, and thus skew data.

PROFESSOR FRANKLIN: Yes.

Q. So is there material that allows you to conclude that there is underreporting in this group?

DR GREENAWAY: So if we look at the Hesley Group, that report, the fact that the children within that setting have been suffering abuse from within the setting, they weren't able to --

(Audio interference)

LADY SMITH: That should be fine.

MS INNES: We'll try again. So you're referring to the Hesley Review, and I think you were saying that the fact that children within those settings weren't able to report abuse.

DR GREENAWAY: So there's different -- there can be various reasons as to why that is.

Firstly, they -- are they able to understand that what they're suffering is not acceptable, that it is abuse? That they have the means of communicating, or finding out that they can report it somewhere, and do they have the communication tools to be able to do that to a person outside of that setting, or a safe person within that setting.

So there's various different reasons as to why that can be. And we look at, for example, the adults in the Winterbourne View, which is adults, but again they were prevented from, or weren't able to know where to report or to -- what was happening to them wasn't right. I mean, this is where advocacy is really important, actually, but I'm sure we'll pick that up later on. Independent advocacy to have somewhere where -- or have an eye there that's independent that can support a person to be able to report or to say what might be happening to them.

Q. Okay.

PROFESSOR FRANKLIN: Sorry, is it okay to just add to that, because I think what we found as well with the research evidence, when you look at generic studies of child abuse, which has relied on the reporting of survivors of

abuse, quite often, they will exclude disabled children or disabled adults from those studies, because they will say that their methods aren't accessible, or they do not have the cognitive abilities or are able to give consent to take part. So there's an exclusionary process there around research studies that are specifically excluding this group of people.

I think there's also some problems around accessibility in terms of self-reporting. As Jo said, you know, if we're looking at statistics around children who have disclosed, or self-reporting of abuse, they are always going to be lower for disabled children, given the barriers that they face in terms of being able to disclose abuse, or being listened to or being heard, but also in terms of then, at a later date, self-reporting that. And I think as Jo said as well, what we're finding in the historical data is particular problems for disabled survivors to have been able to have learnt or been taught or understood that what they've experienced may have been abuse, because we know, for instance, that very often disabled children and young people aren't given good sex and relationship education. They're not taught about personal safety of their bodies, or consent. They're not taught about those issues, or they may have experienced medical or chemical

abuse that may have been seen at that time as not necessarily abusive.

So there are -- there's all sorts of problems in terms of historical and research data around self-reporting.

Q. Okay.

DR GREENAWAY: And just to add, as well, that we know that survivors of abuse are sometimes not able to say, anyway. So it's not specific just to disabled children, but I think it's even more prevalent within that, because of the communication and their knowledge and understanding, in the way that people treated them, or the value that they're given to their voices, but also to the education and their understanding of what is okay and what isn't okay.

Q. Okay.

Now, if we go on over the page to page 12, in the first paragraph there you refer to, I think, the Radford Review drawing upon Biehal's study from 2014, and the study found lower rates of allegations and confirmed abuses in care settings in Scotland than in England and Wales, and I think the review said it was unclear whether that reflected a real difference or whether it reflected differences in thresholds.

And then you say:

'The analysis did not disaggregate estimates for disabled children, although this group of children are overrepresented within residential settings.'

So again, there's material that you can rely on that confirms that disabled children are overrepresented in residential settings?

PROFESSOR FRANKLIN: Yes, and there is, I mean, the statistics and the work of Alex McTier up here in Scotland has provided statistical evidence around the increased prevalence of disabled children in residential settings, but there is also evidence from across the world that that is the case, that there's almost the increased risk, when you look at abuse in institutions for disabled children, is there's increased risk for disabled children but there's also increased risk because they're more likely to be in institutions, so it's that sort of double element of risk for this group of children that I think is really important to draw attention to and there are, and we've drawn on McConkey studies and McTier studies there, that actually give statistical evidence on the increased risks of being in residential settings.

And I think the other important thing to say as well with their data is that for this group of children, they are also more likely to stay in residential settings as

opposed to non-disabled children that may go from residential setting into foster care or adoption. This group of children, they're more likely to stay in a residential setting. And I think the evidence from the New Zealand Royal Commission was for this group of children, it's especially important as well to highlight almost a pathway into residential settings for this group, that became a lifelong experience. So for other groups of children, they may leave -- you know, they're going to leave a residential setting and go back into the community. But for some disabled children and young people, it's lifelong institutionalisation, and I think there's some very unique characteristics, I suppose, of this group of children that we should be aware of.

DR GREENAWAY: So a child might -- a disabled child might be in care, not necessarily because of harm within the home, but because of their high level of care needs or health needs which means -- or educational needs that means that the local provision isn't sufficient, or the means that they could stay at home is not there. So unfortunately they can end up in care that way and I think, just going back to the statistics, as well, because some of the statistics look at children in care, they miss out children who are placed in residential settings for health and for education means, as well.

But still can be abused within their settings. It's Hesley, wasn't it?

PROFESSOR FRANKLIN: Yes.

Q. That highlighted that issue?

DR GREENAWAY: Yeah. Yeah. Yeah. It's known, but, you know, the -- that's the evidence there, isn't it? Yeah.

Q. And if we go into the next section on this page, you talk there about challenges around definitions of disability, which you've already mentioned in your evidence. And you note that this was highlighted by McTier as even where disability is recorded, it appears that the definitions are variable across different providers, or different organisations who might collect that data?

DR GREENAWAY: Yeah.

PROFESSOR FRANKLIN: That's absolutely correct. And we spent a lot of time thinking through at the beginning what we mean by 'disabled children', because again there's different terminology, isn't there? There's, you know, in England it's special educational needs and disabilities, additional learning needs, all of these things mean that actually it's very difficult to collate data on this, because are we talking about the same group of children and young people? And that becomes a barrier to collecting data, but it doesn't -- I don't

think that should be a barrier, there should be mechanisms to overcome that. But in the evidence that we've got, the different definitions are creating problems.

Q. Okay. And then you go on to note that:

'Despite the challenges around definitions, evidence from across the world highlights that disabled children are at an increased risk of harm and abuse compared with non-disabled children.'

And then you go on to refer to a study by Fang and colleagues in 2022, which provides the latest and most comprehensive review, and you note that their global analysis showed that disabled children are twice as likely to experience violence as their non-disabled peers. Now, is that as a generality, not just children who are in care?

PROFESSOR FRANKLIN: Yeah. And this is the difficult -- the Fang one, the Fang study was a meta analysis, so it's the best quality evidence we've got around abuse and they use the term 'violence' actually. So again, terminology. That is the best evidence we've got, but it doesn't state where the violence or the abuse occurred. So again, it's very difficult to drill down on that.

I think the important point to say is that there's

many studies that have looked at prevalence or details around abuse of disabled children and they consistently come up with this figure of two to three times more likely to experience abuse or violence, even with the different definitions that they're using. And we found with the IICSA Inquiry, again they are disabled survivors, they were twice as likely to have experienced sexual abuse as well. So we've kind of got pretty strong evidence, despite the terminology problems, of the increased risk for this group of children and young people, in various formats.

LADY SMITH: And Fang was a global study?

DR GREENAWAY: It was.

PROFESSOR FRANKLIN: It was a global study, yes.

MS INNES: And then if we go on over the page to page 13, in the second paragraph there, you mention again McTier, and you say that:

'That summarised that without good quality information about disabled children, then there is a lack of awareness and visibility of this group and of their needs and experiences. This is of significance, especially when concerning disabled children in residential settings, where limited oversight and isolation can exacerbate the invisibility of disabled children and increase risk within the structures meant

to support and protect them.'

Why is there a reference here to children in residential settings having limited oversight and isolation?

PROFESSOR FRANKLIN: I think the concern is if we don't have data on disabled children in institutions, they can become invisible within statistics, or settings, or inspection regimes, whatever you want to call it, and the rest of the evidence just shows the invisibility, often, of this group of children and young people. And I think where you have invisibility, it creates vulnerability.

And I think if children, disabled children, aren't appearing in the statistics, then it's very easy to lose sight of that group of children and young people. Or they're not appearing in statistics around institutions, or settings, we can -- you can forget the specific needs of that group of children if they are aggregated with all children. They have very unique circumstances and require nuanced, holistic care, and I think without the visibility of them, and good information on that group of children, they become invisible, and if you're invisible, then you can become vulnerable.

Q. Okay.

Now, if we move on to page 15 and to section 1.5,

where you refer to material from the United Nations. And you say that:

'The United Nations note that disabled children in institutions are at an especially heightened risk of violence, abuse and exploitation.'

And you refer to a report by the independent expert leading the United Nations global study on children deprived of liberty, stated that:

'Children with disabilities deprived of liberty are at a heightened risk of violence, abuse and exploitation, which may amount to torture and other forms of ill-treatment, including being restrained, shackled, secluded and/or beaten by staff as a form of control and/or punishment.'

So in this study, when it's talking about children being deprived of liberty, does that include children who are placed in institutional care?

DR GREENAWAY: It includes, yes, it's a UN study, so ...

Q. Beyond what you highlight here, were there any other key findings or recommendations in this report relevant to children with disabilities?

DR GREENAWAY: Can you answer that one?

PROFESSOR FRANKLIN: I mean, the whole report is arguing for the de-institutionalisation of disabled children and it's pointing to the -- obviously, the increased risk of

disabled children being placed in institutions, but obviously that in itself increases the risk then of them experiencing abuse. So it was drawing upon the -- obviously, the United Nations Convention on the Rights of the Child and the United Nations Convention on the Rights of Persons with Disabilities, which obviously platforms rights to family life and rights to, you know, inclusion in community. So it was really trying to drill down on the -- I suppose, the discrimination of disabled children in institutions and their rights to alternative -- you know, to family life.

Q. Okay.

Now, if we can move on, please, to page 18 of your report, where you set out the scope and parameters of the review that you carried out. And we can see the research questions highlighted there, so: what is known about the nature and extent of abuse of disabled children in residential care settings? What are the risk factors and how do these differ for this group of children? What are the protective factors and how do these differ for this group of children? How can abuse be prevented? And: what are the gaps in knowledge and understanding, and how could these potentially be addressed?

So these are the research questions that you were

considering?

PROFESSOR FRANKLIN: That's correct, yes.

Q. And you then go on to refer to various definitions, I think, if we go on to page 19, and there's a paragraph beginning:

'Whilst the focus of this review is on specialist institutions designed for disabled children, we want to draw attention to and acknowledge the large numbers of disabled children and children with additional support needs who are placed in other forms of non-specialist disability provision, whose needs have not been diagnosed, assessed, understood and met within those settings.'

And then you go on to refer to a study which highlights many disabled children in settings, such as secure children's homes, with mental health and trauma-related needs who do not receive the support that they require.

So I think you're highlighting there that some children with disabilities, or additional support needs, are placed into specialist provision, but then, more widely, there are children in, for example, secure care who have disabilities.

PROFESSOR FRANKLIN: Absolutely. And I think it's, if you think of disability, I suppose, as a spectrum, you're

going to see children placed in provision that is specifically designed, I suppose, to meet their disability-related needs. So that might be residential special schools, or, I'm trying to think, specialist services for disabled children. But there's also a huge, huge number of children who will have speech and language communication, neurodivergent needs, other needs that won't have necessarily been diagnosed, or have had their needs met, and they will be in other parts of the care estate. So they could be in secure children's homes, generic -- you know, generic children's homes.

There's lots and lots of disabled children, if we are using that term, within other institutions. And we are very concerned in that there's evidence across the board that their needs also aren't being met in terms of people understanding their disability-related needs and having those needs met within those services. Of course, we couldn't do everything in this report so we focused on the specialist services.

Q. Okay. And then, if we look down to the bottom of the page, we see the definition of disability that you used, as you say, you used the definition as it appears in the Equality Act 2010, and you adopt a social model definition of disability --

PROFESSOR FRANKLIN: Yes.

Q. -- when you're undertaking this report?

DR GREENAWAY: Yes.

Q. And then if we go on over the page, to page 20, we can see, under section 2.3, the evidence that you reviewed from various sources, including peer-reviewed journals, relevant case reviews and significant case reviews from within the UK, and international inquiries and commissions. So, for example, the New Zealand work that you've already referred to. And also some grey literature.

And you then go on to set out the inclusion criteria, and if we go to the top of page 21, you were looking at papers and reports published since 2014, because we're focusing more on the current context in your reports, is that right?

DR GREENAWAY: Yes.

Q. And then, if we go down to 2.4 on page 21, we can see that you highlight that overall the review found a paucity of research evidence examining abuse of disabled children in institutions. And then, for example, when you looked at peer-reviewed journal articles, 68 fell within the scope, but only three fully met the criteria.

DR GREENAWAY: We were quite shocked with that, to be

honest.

Q. Sorry?

DR GREENAWAY: We were quite shocked with that, to be honest.

Q. And you note the reasons why, so for example, at the bottom of the page, the reasons why certain, well, 65 articles didn't meet the full inclusion criteria, and so this was they didn't refer to abuse within residential care, the findings weren't specifically concerning disabled children, so disabled children weren't disaggregated, or they were more in relation to general issues.

And if you go on over the page, you look at some Scottish articles, and you've got a table there highlighting various works, I think, none of which meet -- are about the abuse of disabled children in a residential setting, so meeting those three key criteria?

DR GREENAWAY: Yeah.

PROFESSOR FRANKLIN: And that was the challenge all the way through, was the three -- the three elements coming together in the research evidence to be able to answer those questions, and that just was very rare in terms of academic research and, to me, it feels like that that is just a form of disablism actually, that we haven't got

that real research evidence base from academic studies. And we were quite shocked. We've read thousands and thousands to try to get and find, and we ended up with, what, three articles that fully met that inclusion criteria. And I think that does come down to research funding and the lack of funding available to be able to look at this issue.

LADY SMITH: Is it also, as you were saying earlier, because of the lack of the requisite data?

DR GREENAWAY: Exactly.

LADY SMITH: And that goes back to establishing practices of recording the relevant data for what would be our purposes, for example.

PROFESSOR FRANKLIN: Absolutely. And I think it's the combination of both, because I don't think there is -- there isn't funding accessible to even begin to collect the data, as well. So it's a combination of all of those factors that run through this.

LADY SMITH: Yes, thank you.

MS INNES: And if we can go on, please, to page 23, where you refer to the individual case reviews, and your consideration of material in relation to this. And here, again, you identified only one significant case review, and one learning review, concerning disabled children who've been accommodated in residential care in

Scotland, and one of those, 'YP D', really focused on the period when the young person had become homeless at the age of 16. So it didn't fully meet the inclusion criteria, but you did look at that as well.

DR GREENAWAY: I think by that stage, you know, we'd gone through an awful lot of serious case reviews to -- or significant case reviews, to try and find evidence for individual children. And it was important that we sort of widened the scope a little bit. So some of the children --all the children that we did look at had at one point been in a specialist support residential care, because it met their disabilities or was attempting to meet their disability needs. So that's -- we ended up stretching the criteria a little bit for that. But there's some really important learning, I'm sure you'll come to it.

Q. Yes, you mentioned that in relation to looking more widely in the UK, you also identified nine serious case reviews, or safeguarding practice reviews, considering individual disabled children's experience of abuse whilst in residential care, and you also identified a report for Beth which was known to the reviewers, and you were able to identify that from your own knowledge?

PROFESSOR FRANKLIN: Yeah.

Q. Now, at the bottom of the page, you mention ... you're

looking there at wider reviews, so not just reviews in respect of individual children, and you refer there to the review of the Hesley Group in England, and you rely on this quite extensively throughout your report. So what was the background to the Hesley Review?

PROFESSOR FRANKLIN: I mean it's had -- it received a lot of attention in England because it was a group of children's homes for disabled children, and it came to light that there was significant abuse within that Hesley Group. So there was an independent review of what had happened in that particular case, and there was particular focus on 108 children who had been placed in those settings, who had been abused in those settings. So there were two reports published as part of that, and it was a government review undertaken independently.

It was very thorough, so we have drawn on that extensively, although we are aware that that is just -- that is one setting.

Q. Yes.

PROFESSOR FRANKLIN: But I think it's important to say that although that is something that we've drawn on heavily, it's because there was that independent scrutiny of what happened there. We're aware of many other settings and there have been many other scandals and TV programmes and, you know, press reports on other settings, where

groups of children have been abused, disabled children have been abused, but they may not have necessarily received the attention that the Hesley Group did.

So I think it's important that, you know, that is the evidence we have, but I think it's also important to state that there are other settings where we know abuse has happened in those children, but they have not received that level of review or scrutiny.

DR GREENAWAY: The 108 children at the Hesley didn't receive a serious case review for each of their -- for what happened to them as individuals.

Q. They were all dealt with within the group?

DR GREENAWAY: Yeah, they were, yes, yeah. Yeah.

Q. And if we look on to page 24 at the bottom of the page, there's reference to other inquiries, and you mention the evidence gathered as part of the Royal Commission into the inquiry of abuse in care in New Zealand, and you note some bullet points which are the reasons why you looked at this, because this looks at the narratives of disabled people themselves, it's disaggregated from the stories of other adults, and it provides details of how disabled children in New Zealand disproportionally entered care and disproportionally experienced abuse and neglect, in contrast to non-disabled children.

PROFESSOR FRANKLIN: I think it's also important --

I reflected on this again, and actually it would be nice to add some more bullet points here, because I think the New Zealand work was particularly important because it threaded disability throughout its -- the commission. So particularly with the recommendations, you can see the disability running throughout and I think it's because they very strongly highlighted disablism that was impacting on this group of children throughout processes and systems within the New Zealand context.

I think the other thing that's important with the New Zealand Royal Commission is the fact as well that it looked at disability intersectionally, so although it focused on disabled children, it also talked about their cultural needs, it talked about -- and it placed a focus on deaf children as well, and it was hard to find other evidence of studies that had looked at deaf children.

So I think there's an awful lot of good evidence within that New Zealand study that I think is quite important in drawing out some of those issues around disability, disablism, and identity and needs of this particular group of children and young people.

Q. And then if we look on to page 25, and to the bottom of the page, as you highlighted a moment ago in your evidence, that there are cases of abuses within residential settings for disabled children where there

have been perhaps press reports. But from what you say, that doesn't necessarily then translate into official documentation reports or investigations through publicly available sources?

DR GREENAWAY: Mm.

PROFESSOR FRANKLIN: And that, I think, is incredibly important, not just in terms of, you know, these stories hitting the headlines for a few days and then -- you know, it's this invisibility, then what happens? And I think it was very hard for us to -- -we followed these things, we tried to find the reports, we tried to find the inquiries that had happened to some of these exposes and scandals and whatever we want to call them and we couldn't find that. And I think that is incredibly important in terms of access to justice for those people, but also in terms of learning about what went wrong and what could be improved in those particular settings. So we do talk in the report about this lack of transparency around what happened and what could be learnt about what went wrong in those particular cases.

Q. Okay.

Now, if we move on to page 27, and this moves on to your findings. We can see the first question is about the nature and extent of abuse of disabled children in residential care settings.

Then if we look down to '3.1.1', dealing with 'prevalence and extent of abuse', you refer to three journal articles. I think the first one, well, maybe the first and the second, Euser and Wissink, are from the Netherlands?

PROFESSOR FRANKLIN: That's correct, yep.

Q. The first one considered the prevalence of sexual abuse of children with mild intellectual disability in foster and residential care in the Netherlands, and the data set is based on reports by professionals, not from the children themselves?

PROFESSOR FRANKLIN: That's correct.

Q. And what impact does the fact that that's the source of the data, what impact does that have?

PROFESSOR FRANKLIN: I mean, whilst it's an important study in the fact that it is one of the very few studies that we have, there are limitations in the fact that if it's based on self-reporting, it's reliant on staff reporting in the first place, which is reliant on them feeling confident, able, to report the abuse but also to not be part of a closed culture that doesn't allow the reporting of abuse. But it also relies, I guess, on staff recognising that something is abusive and what we know from other evidence is that for disabled children and young people, the value we place on some disabled

children and young people means that some people don't necessarily see things as abusive, that they may do, you know, in other children and young people. So I think that's the main limitations with some of the staffing, it's dependent on people recognising and reporting this in the first place.

Q. Okay. And then in the next study, you refer to the statistics arising from this, and it's examining the prevalence of child sexual abuse within care, comparing those with and without intellectual disability. And 85 per cent of reported cases were found to concern a child with intellectual disability who was placed in residential care, and then nearly half of the cases were suspected as being as a result of what was described in the report as group, mate or peer abuse?

PROFESSOR FRANKLIN: Yeah.

Q. So what was the significance of those findings?

PROFESSOR FRANKLIN: The -- I think what that is drawing attention to, and you can also find statistics in this in the IICSA child sexual abuse inquiry, is the fact that there are statistics around higher levels of children causing harm to other children or, as they've called it here, 'peer abuse'. Many different terms are used around this. And I think it's drawing attention to the potential risks of that within settings, but I think

in the case of talking around disabled children who may harm other disabled children, I think it's really important to understand the nuances of that.

So in this particular study, we don't necessarily know if it was the case that it was easier, or the staff felt more able to report peer-on-peer abuse of -- rather than, you know, if it was staff abuse on a child. We don't know about the reporting processes within the study. But I think the important thing to think about in terms of disabled children who may harm other disabled children is some of the nuanced understanding around how risk is assessed for a child being placed in the setting, and in terms of the risk to the child being placed, but also risk to the other children within that setting, and we do talk about evidence of that not being great, in terms of understanding that risk, where maybe priority is placed on the disability-related needs of the child and not necessarily the risk of harm.

But I think it's also important as well to consider the evidence later on as well around this sort of whole terminology of harm to other children, because we do know for disabled children and young people, they aren't often given support to understand maybe what harmful behaviour looks like, or is. So they're not supported around sex and relationship education, they're often not

supported around understanding consent. So there are specific issues and nuance around talking about harm of other -- you know, by other children within these particular settings that sort of needs to be unpicked with this group of children.

Q. Okay.

And then if we go on to page 28, we see the third study that you refer to, Hoffmann and colleagues from 2020, and this is a retrospective study of people aged between 14 and 91 who'd had childhood experience of hospitalisation. What country was this from?

DR GREENAWAY: Germany.

PROFESSOR FRANKLIN: Germany.

Q. And this gathered -- identified differences and experiences of maltreatment by staff, and I think it compared reports of maltreatment in psychiatric care as compared to maltreatment in general hospital care, and you tell us that the percentage of reports in respect of psychiatric care was higher. But then you go on to refer to some of the limitations of the study, including that recollections may fade, that some participants may not wish to have divulged abuse or maltreatment, nor declare whether they had been hospitalised. The study highlights that participants may not have been able to distinguish between treatment that was indeed

maltreatment, or treatment that was necessary. And the authors draw attention to the fact that definitions of neglect and harm may not have been fully understood by respondents to the questionnaire. So there appears to have been a number of concerns that the researchers suggested in relation to the data that had been collected?

DR GREENAWAY: Absolutely, yes. Yeah, yeah. Because the study was collecting data on childhood experiences and weren't specifically asking the questions about abuse within settings, it ended up being that because of the definitions, they weren't sure to look back to check that the participants were telling the whole story, or all their story. It wasn't specifically about the abuse within settings. So it's a little bit -- so from a research point of view we included it, but we wouldn't necessarily say that it was the most robust study there.

Q. Okay.

Now, if we can move on to page 29, where you talk under the heading 'Nature of abuse'. Again, you say:

'Evidence is limited by the focus of the studies themselves because the studies that we've already looked at, the ones from the Netherlands were focusing on childhood sexual abuse and then Hoffmann was looking at experiences of hospitalisation, so that could be

a broader range of abuse.'

However, you've already highlighted some of the issues with that, including that cultural, political, social and healthcare changes in approaches over the decades mean that the experiences of younger adults might differ from older participants, because there was quite a wide age range, as we've seen.

You then go on to refer to the 11 case reviews and reports that you've looked at, and you say that there is a variety of abuse mentioned, including physical restraint, sexual abuse, and you also note some dehumanising events and conditions that were highlighted within these reports?

DR GREENAWAY: Yes, yeah. I think the -- 'Beth' is one of the cases. It wasn't actually a serious case review, it was a report, a government report, based on ... I couldn't find the rest of the report, basically, but it was a response to it, talking about the fact that she had been sedated and stripped naked. It was quite a publicly -- I'm trying to think of the word --

PROFESSOR FRANKLIN: A high-profile case.

DR GREENAWAY: Yeah, yeah.

PROFESSOR FRANKLIN: I think we talk more about dehumanising treatment further on in terms of looking at the evidence from survivors in the Royal Commissions, and some of the

IICSA and Hesley. There's very detailed information on dehumanising treatment of disabled children in those, and very specific examples that are linked to being disabled.

DR GREENAWAY: Yes.

PROFESSOR FRANKLIN: So, you know, the treatment here, you know, obviously oversedation was in 'Beth's' case, but it could be dehumanising treatment in terms of having a child's ability to communicate being taken away from them. So there are many examples throughout the report where we can -- we -- where there's evidence of dehumanising treatment.

DR GREENAWAY: Yes, it's not just 'Beth' and Child MM.

Q. Yes, if you go on over the page, you look at -- there's some bullet points there highlighting some of the issues from Hesley, I think, so systematic and sustained physical abuse. Then emotional abuse. Cruelty and neglect. Bullying and taunting were a feature of life in the settings, it's said, with emotional abuse being described as significant and varied, manifesting itself in children rocking or head banging to self soothe. Sexual harm. Poor quality of care, including children being deprived of communication methods, for example?

DR GREENAWAY: Yes.

Q. And medication not being properly administered.

And then you also refer to the New Zealand study, which highlighted a number of different types of abuse. That's at the bottom of the page.

DR GREENAWAY: Mm-hmm.

PROFESSOR FRANKLIN: I think there was one other, if it's okay to mention, in terms of the nature of abuse. And I think this was something, I mean, maybe many people wouldn't necessarily think of when they think about abuse within institutions. But within the 11 serious case reviews that we looked at, out of the 11, seven had experienced significant harm outside of the home. So although that may seem outside of an institution, those institutions had responsibility for keeping those children safe. So I think it was important to sort of highlight the fact that the harm may have incurred outside, but there was a responsibility for those institutions. So actually seven out of 11, you know, is demonstrating the failure, I suppose, of those institutions to keep those children safe. It was also featured in Hesley as well, the sort of -- the vulnerability of children to outside homes. But they are placed within a setting that should be keeping them safe.

Q. Okay.

LADY SMITH: So you have in mind, where a young person has

been placed in a particular setting, or a particular institution, but their vulnerability is such that when they are outside the home, for whatever reason, they may be abused and have been abused?

PROFESSOR FRANKLIN: Do you want to say --

DR GREENAWAY: Yeah, I suppose there's a bit of a nuance around that, because sometimes, because needs are not met within the home, they've absconded, they've ended up being groomed within the home, and then been abused outside of the home. So it's more about their needs being met, not necessarily that they've gone to, but it's -- the disability needs are not being met that has meant that they have become, I don't like the term 'vulnerable', but they have --

PROFESSOR FRANKLIN: I think it's a lack of understanding within those institutions about the vulnerability or the needs of those children in order to keep them safe. So there's some very specific examples of children who've been under deprivation of liberty orders, where they should have been kept safe within that environment, but for whatever reason they had been -- had not been kept safe within that environment, and had been able to, you know, come out of that home and had been abused by gangs in the local area.

There's a particular case highlighted in the IICSA

around organised networks around child sexual exploitation, and there are cases identified in there where children have been groomed within their children's settings, so they have been -- you know, they haven't been protected within that setting and obviously they've gone out into the community and have been exploited and abused in the community.

So I think it's an important point about the abilities of those institutions to be able to keep those children safe.

LADY SMITH: It's also for the institution to recognise that running away, and I have heard a lot of evidence about children running away, absconding from places they have been put, and not necessarily under any order of detention there.

PROFESSOR FRANKLIN: No.

LADY SMITH: That when the children do that, they are at risk. And the risk sometimes come to fruition, but even if it doesn't, that's not the point.

PROFESSOR FRANKLIN: No.

LADY SMITH: Because the children have been put at risk, including -- and I've heard of some disabled children being put in that position --

PROFESSOR FRANKLIN: Yes.

LADY SMITH: -- or being put out of an institutional vehicle

because of something that's been happening, and left.

PROFESSOR FRANKLIN: Absolutely, and I'd concur with that. Our other research is around child sexual exploitation of disabled children and young people and, absolutely, we see patterns of that repeated.

LADY SMITH: But the problem for people like you is that doesn't get recorded at the time.

PROFESSOR FRANKLIN: It doesn't get recorded.

DR GREENAWAY: No.

LADY SMITH: Until you get an inquiry like we've got, and people come along as adults and tell us what happened when they were children.

PROFESSOR FRANKLIN: Absolutely. Or we are fortunate enough to get a small amount of funding to look at small groups of children and young people, and begin to unpick and explore some of this nuance.

LADY SMITH: Yes.

PROFESSOR FRANKLIN: But that is few and far between.

LADY SMITH: Yes.

Ms Innes.

MS INNES: Thank you, my Lady.

If we can move on to page 31, you refer there to Gil identifying three distinct forms of institutional abuse, and then you go into look at each of them. So you say this provides an important framework for considering how

change needs to happen at multiple levels.

So direct institutional abuse refers to physical and emotional abuse imposed by a caregiver.

Then you have programme abuses, which are to do with practices that are in place in, for example, residential institutions, and the practices themselves are abusive.

And then, if we go on over the page, you refer to systemic abuse, which is the inability of a structure to guarantee the protection of children in care, and this is where there are systemic failures.

Now, why do you say that this offers an important framework for considering matters?

PROFESSOR FRANKLIN: I think it does because I think there is probably a general perception that abuse is sort of individual, or maybe, you know, is just sort of the -- sort of, direct abuse of one person to another. And I think that has sometimes been the focus of research, looking at, you know, experiences of abuse. I think that by not highlighting programme abuses, or not highlighting systemic abuse, we're not focusing on the mechanisms, the systems, the processes that actually are enabling abuse to take place, and I think, without that focus on those levels, we are doing a disservice to protecting children and young people.

Q. Yes, I think you summarise this at the end of the

section on page 33, in the paragraph beginning 'In summary', you say:

'We found evidence of all of these forms of institutional abuse, albeit within a very limited evidence base.'

And you say:

'It's important to highlight that there has been a lack of attention in research, possibly ... due to a lack of funding, to examining the particular issue of systemic and programme abuse.'

Which is what you've just said:

'This points to the need for a more sophisticated research design. Without data of this nature, it's easier for those in power to ignore the issue or dismiss it as single incidences rather than a systemic issue.'

So it's a one-off, as opposed to some systemic problem which can be resolved?

PROFESSOR FRANKLIN: And I think it points to the point we just made around we can do small-scale studies that maybe will look at -- you know, I've done it myself, I've undertaken small studies that have looked at 30 children, 30 disabled children, who have experienced child sexual exploitation. And you can report their stories. But it's very easy then, isn't it, for people to dismiss that, because it's a small scale. But

actually if you look at what the evidence was saying, there was repeated patterns, there's repeated points at which intervention and different systems and processes could have protected those children, but without the investment in bigger studies that are looking at these things, it's very easy, isn't it, to then look at it and think it's a single incident.

And quite often, you know, children are blamed, or they feel blamed, because they think they are the only one. But actually it's that they're a part of a system and a process that's not protecting them.

Q. Now, in the next section at the bottom of this page you go on to look at the risk factors for disabled children, and you've broken this down into four different areas so: a lack of appropriate placements; assessment of risk within the institutional setting itself.

Then, going on over the page: inadequate external monitoring, scrutiny and national policies and then: risk inherent to disability-related factors.

And then you go on in your report to look at these in some detail.

So if we start with a lack of appropriate placements, you refer in the first paragraph there to the evidence from individual cases and Hesley illustrating a picture of lack of resources and adequate

provision. And that then directly impacts on the ability of the system to provide appropriate settings for children. You say:

'Inappropriate placements can lead to increased risk of harm to disabled children when staffing and training is inadequate and the service provision is not appropriate to meet the needs of the child.'

And then you break this down further. So you go on in the next section to look at insufficient provision and inappropriate placements and you first of all refer to the report from the Children's Commissioner for England in 2020, and you say that they -- or the briefing that they prepared, indicated that the standard of care for such children with complex mental health and physical health needs was variable. So was this a, sort of, widespread review that the Children's Commissioner did in England?

PROFESSOR FRANKLIN: Yes, absolutely, and I think what it was trying to do was point to the lack of provision and support available for disabled children and young people. So in this case they used the term 'Complex mental health and physical health needs', but there are other reports that maybe will use slightly different definitions. But collectively what they're talking about is a lack of provision for disabled children and

young people and we'll probably talk about how the impact of that is actually leading to more children going into institutions because there isn't the provision to support their families in terms of that early help. But here, if we're looking at risk factors in terms of the placements, what it means is there's a lack of provision in terms of placement. So there's limited options available for local authorities, and the evidence is pointing to the fact that, because there's limited options, it can mean that children are placed in inappropriate placements, or they're placed a long way from home, or the placement isn't meeting their needs. So it can increase instability in multiple placements.

But the other important thing, I think, for this particular group of children is that if a placement isn't able to meet the child's needs, then it can particularly increase risk for abuse, or a lack of care to support that child and there are a number of examples we've put in the report where, particularly children with communication needs, if there's not an understanding within the placement of how to meet that child's communication needs, then obviously their behaviour, their tension, everything can just escalate and it can lead to an increased use of restraint and other mechanisms that can be abusive.

So there's nuance around this placement issue. And I think the other thing to mention, because there's a lack of placements, there's the distance that many disabled children are being placed away from home and I think it goes back to that point of if you're a long way from home, you can become invisible, and invisibility leads to vulnerability. So there's a lot of nuance around placements that, sort of, needs to be unpicked.

Q. If we go on over the page, so you refer to some other reports on a similar theme, and then you refer to the Lenehan Review in 2017. And then it says that:

'Yet these concerns were still noted within the evidence we reviewed on cases of harm to disabled children. The significant case review for 'Isabelle' from 2020, for example, identified that resources are not currently designed to meet the needs of some young people with complex needs, including autism, running the risk that the care that they receive is inappropriate.'

So that makes the suggestion that the resources aren't in fact there at all. Did the review make any suggestions as to how the resources could be designed to meet these needs?

DR GREENAWAY: I can't remember directly, but I know that one of the big factors as far as, so -- you know, social

records will tell you, it's about money; so resourcing, what's available in the local area to meet the needs of those children at the sort of early help stage. And the more that a family tries to support and meet the needs of the child, but they're not being resourced themselves, that's when things can escalate. It may do it anyway, but because we're not having that early help we can't actually see what early help is effective, and you end up being in a situation, and, I mean, I was talking from my social work experience as well, is that you end up having a child who's family has been desperate, been asking and asking, the resources aren't there locally, you try different things, it's not working, and they end up having an incident, or something happens, and the child, emergency placement, then ends up being shipped 200 miles away. And this is the experience of social workers we've talked to. This is not unique to my experience. This is just -- this is what happens, this is what the parents, from the Challenging Behaviour Foundation, from other places have said, this is what the reality is for these families, and a lot of it comes down to resourcing, which is money.

But then, of course, if you don't have the evidence that you have children with those needs that need to be

met, then it's about commissioning, it's about funding, it's about budgeting for that, so it goes right the way back, really.

Q. And if we go down on this page, we see the heading 'Unmet needs before and during residential placement' and you refer there to Hesley, where 12 children, in respect of whom there was detailed analysis, there had been a long history of unmet needs, placement breakdown and suchlike.

And then at the top of the next page, it says:

'The review illustrated that while these challenges were known about by services, there had been little intervention to address them. It was highlighted that the child's disability became the focus with little attention given to these other concerns. And you say:

'Other studies have also highlighted how a child's disability can overshadow the identification and response to abuse in these cases albeit [the context is] within intra-familial harm or exploitation.'

Can you explain a bit further what is meant here where you're saying that a child's disability can overshadow the identification and response?

DR GREENAWAY: So if a child displays behaviour that others find challenging, challenging behaviour, there is various terminology but the focus being on a child

communicating in a way that's challenging, that can be seen as just because they have a disability, or the disability is the cause of it. But actually it's not looked at why their behaviour has changed, or they're suddenly displaying challenging behaviour, or things have moved on. It could be for a number of reasons. But it's not really looked at as a potential -- that abuse may be the potential cause of it, it's like, 'Oh, it's just their disability, they're autistic', they're -- you know, these are the labels that are often bandied around, aren't they? So it's -- that's what we mean by overshadowing, the diagnosis can overshadow other things that are going on for that child's life.

PROFESSOR FRANKLIN: And I think there's -- it's important as well to highlight the way in which services are organised, so that often a child, a disabled child, will be known to disability services, but those practitioners in those settings won't necessarily have been very well supported or trained to understand child protection issues and if you're in a child protection system, they won't necessarily have been trained and supported to understand disability. So you can see that disabled children fall through a gap. So you've got, often, practitioners around them that won't necessarily understand the overlapping concepts of disability and

abuse, and how that may present in that group of children and young people.

So you can see that if you aren't trained to understand the signs and the indicators that disabled children may display to indicate that they are unsafe, or at harm, then quite often it can be seen, as Jo said, a manifestation of autism, or whatever, and we found that in other studies, not just within institutions, but within child sexual exploitation, within studies that have actually been done up here in Scotland by Kirsten Stalker and others, that the focus can become disability and we forget the other needs of that child.

LADY SMITH: Well, perhaps they also forget that the child is trying to tell them something.

DR GREENAWAY: Exactly.

PROFESSOR FRANKLIN: Absolutely.

DR GREENAWAY: Yeah, behaviour is communication.

MS INNES: Now, if we move on to page 39, you start talking there about risk factors within the institutional setting. And you say there that:

'A recurring theme is the inability of institutions to understand and meet the needs of disabled children placed within their care, and this was often linked to poor training, supervision and a failure to follow the care plans of individual children.'

Now, so just pausing there, and we'll go into it in a bit more depth, the material that you looked at highlighted that there were still issues about poor training and supervision of staff?

DR GREENAWAY: Unfortunately, yes.

PROFESSOR FRANKLIN: It's consistent across all of the data that we saw that this -- I suppose it's the combination of training and the investment of training in -- across the board at different levels of professionals who work with disabled children. We don't necessarily value those skills, the expertise, the knowledge that you need to work with this particular group of children. And in institutions, staff often are low paid, don't have access to training, there is a high turnover of staff because of, you know, the conditions and the pay, we know, and that's been highlighted in many of the studies and was highlighted in Hesley. So that lack of investment in the staff, I suppose, is also reflective of the lack of value we're placing on the work of those professionals working with disabled children.

Q. And in the second paragraph here, you refer to a work by 'Craig', but just before that you say:

'In some instances, placements are believed at the point of commissioning to be able to meet the emotional and behavioural needs of children.'

So at the time that the child is placed, it seems like the right place for them. But then other factors mean that the child remains at risk?

DR GREENAWAY: Yeah, so that can be for -- so there's two factors here. One is that the child's needs are not being fully recognised, and then the other, another reason can be, for example, with 'Craig', was he was abused by another child within the setting -- or harmed by another child within the setting, and there was not the risk assessment, and that sort of thing, put in place. So it's -- so then that ends up escalating, or meaning they have additional needs, or behaviours, as a result of what's happened within the setting.

PROFESSOR FRANKLIN: I think there was a couple of important points as well within the data that we analysed across the board, was that quite often children are placed in these settings at a time of crisis, so there'll be a breakdown in the family setting, or there'll be a breakdown at the school, so --

DR GREENAWAY: Or even in the previous placement.

PROFESSOR FRANKLIN: Or in the previous placement.

DR GREENAWAY: Yeah.

PROFESSOR FRANKLIN: So local authorities are having to make decisions quite quickly in order to make these, you know, to place these children in these settings. And

I think that can obviously impact on abilities to do planning.

I think the other thing that came through as well in terms of Hesley was the fact that the setting and the Hesley Group, all the reports, the information, everything that was provided, looked as though they were able to meet the needs of the group of children that they were supposed to be supporting, so they had in place the procedures, the policies, that indicates that they can meet the needs of that child, but obviously, as we found out, they quite clearly weren't meeting the needs of those children and were abusing them. So I think there's a difference between what's on paper and the abilities of a local authority, potentially at a distance, being able to understand what a placement can offer versus the reality.

DR GREENAWAY: And I think we've also got to recognise, I suppose into that bit about 'Craig', but the trauma of moving placements may not be a factor that is really in the assessments, or the needs, understanding of that need to be trauma-informed, but also to recognise the impact that that might have on the child short-term, as well as long-term. Unfortunately, a lot of the children were moved, certainly in the serious case reviews, several times.

Q. If we move on to page 40, there's a heading 'Poor leadership' as a risk factor and you identify that this was a consistent factor leading to poor practice. And you note again that the Hesley Review highlighted that poor practice was allowed to flourish with children not receiving the support that was detailed within their care plan and which the provider was funded to deliver.

So that mentions what you've just said there in your evidence that, on paper, it looked as though it was going to meet the needs. How were leadership failings impacting on children in that setting?

PROFESSOR FRANKLIN: Within the Hesley report, there is a lot of evidence about the lack of leadership within the setting. But also the abilities of the leadership within that setting to be over what was happening. So there were instances where staff were raising and whistleblowing and raising concerns, but they were ignored by the leadership. So I think there's something there about accountability of leadership. But also training and understanding actually of the needs of those children within their care was missing.

And I think the other thing around leadership that Hesley noted as well was the fact that this was a setting, a home, but it was also a school. So the disconnect between the leadership in the two and the

disconnect between safeguarding across the two, because the children were living and going to school there, there were issues around that working together and being accountable. So there were a number of levels where leadership failed in terms of accountability, understanding and being, you know, on top of what was happening.

Q. Okay, we'll come back to that in due course, because you describe that as a closed setting so --

PROFESSOR FRANKLIN: Absolutely.

Q. -- we'll come back to that.

LADY SMITH: Shall we stop there for the morning break?

MS INNES: Thank you, my Lady, yes.

LADY SMITH: We'll take the morning break now for a quarter of an hour or so and then get back to your evidence after that.

Thank you.

PROFESSOR FRANKLIN: Thank you.

(11.30 am)

(A short break)

(11.45 am)

LADY SMITH: Jo, Anita, welcome back. Are you ready for us to carry on?

PROFESSOR FRANKLIN: Yes, thank you.

LADY SMITH: Thank you very much.

Ms Innes.

MS INNES: Thank you, my Lady.

If we can go to page 41 of your report and under the heading 'Cultural and racial disparities', this was something which was drawn attention to again in Hesley which you say drew attention to a clearly neglected area of research by seeking to address how and where there may have been racial disparities in the experiences of disabled children. And for example, you note that the review indicated that some children were denied their own culture and identity, with black female children having their hair shaved, for example.

And you then note at the end of this paragraph:

'The Hesley Review's recommendations call for the promotion and embedding of culturally intelligent practice and the addressing of issues such as racial stereotyping and cultural bias.'

And you say to that that you would add recommendations specifically also concerning deaf culture, identity and language. And why was it that you highlighted these particular issues?

PROFESSOR FRANKLIN: In terms of deaf culture --

MS INNES: Well, and --

PROFESSOR FRANKLIN: -- and the issues? I think it's -- overall, I think it's very important that when we talk

about disabled children, we see the intersectionality of their lives. And I think it's -- what that evidence showed was that there wasn't attention given to the identities and the needs of, particularly in that case, black and ethnic minority children.

I think the New Zealand Royal Commission, as well, was very important in the fact that it also raised issues and examples of abuse of deaf children, and the way in which those institutions didn't meet the needs of deaf children. So again, there was examples of them not being able to use sign language, or an understanding of deaf culture. So I think it was very important to both highlight where children were abused on the basis of a different identity, or a different culture or a different need, but also the fact that the settings weren't meeting those needs as well, so ...

Q. Over the page on page 42, under the heading 'Issues and handling risk' you've obviously already dealt with issues about risk assessments as between children and the issues that a failure to undertake proper risk assessment can give rise to.

Here, you refer to an Ofsted inspection report of Calcot Children's Home in 2022, and you note that the report said that managers had failed to respond appropriately to serious incidents and this has placed

children at risk of harm and, for example, there was a failure to take into account risk assessments. So even if there has been a risk assessment, if somebody --

DR GREENAWAY: It's acting upon it.

Q. Sorry?

DR GREENAWAY: It's acting upon it.

Q. Yes.

And then you note that potential risks relating to sexually harmful behaviour were not assessed and no safety plans were therefore put in place to prevent a similar incident recurring. So that's not about assessing the correct risk?

PROFESSOR FRANKLIN: Yeah, and assessing the risk of a child, but at the risk to other children and understanding the nuances around that. And I think, although we have highlighted it in that report, it came out, actually, in some of the serious case reviews that we looked at as well.

Q. If we go on over the page to page 43, at the top of the page you highlight there again something that you've mentioned in your evidence already, and this is to do with the lack of accessible sex and relationship education for disabled children, and that represents a significant safeguarding gap. So again, from the research, is this something that you've identified as

a theme?

PROFESSOR FRANKLIN: Absolutely. I think it's important, at the outset, to sort of place that in context, because obviously what we're saying is it's a right to have accessible sex and relationship education, and to be able to understand issues of consent, but I think it's important to say that that in and of itself, we shouldn't be placing responsibility on children to protect themselves. This is about them having a right to that education. And I think across the evidence that we've presented in this report, and other studies in different settings, this gap in attention to providing that provision, that education for disabled children to understand sex and relationship education, their own personal space, their own privacy, particularly if they need personal care, there isn't that importance placed on teaching children those important lessons that many of us learn. And that comes across, across all evidence.

I think if we're talking particularly here in institutional settings, and the focus of this, what the evidence drew was the fact that there wasn't responsibility taken often by the residential setting and the institution to provide that education to those children. So -- and that could be a lack of, you know,

it could be a lack of support, training, for staff to be able to do that. It can be taboo, it can be embarrassment. There was evidence that you don't want to raise these issues or talk to these issues because, you know, that would mean that children would go out and explore, you know, their sexuality. So there was sort of barriers at various stages which meant that often children and young people weren't given the information, the tools, the experience to able to understand sometimes what was happening to them. And so actually that leads itself to not understanding when things were abusive.

DR GREENAWAY: And I think sex education for different children with different needs requires different approaches. And that's not always a one size fits all for your educational sex education pack, it doesn't work for a lot of children and it might need repeating, it might need to be said in different ways, it might need to be a variety of tools, and I think that that's where it becomes quite complicated, looking at the individual children's needs, and their means of communication, or the way that they understand, and how you draw in and explore sex and sex education with them in appropriate ways for their particular learning needs and understanding.

PROFESSOR FRANKLIN: It was a particular recommendation in IICSA around improved sex and relationship education and staff training around child sexual exploitation. They obviously found evidence throughout their inquiry as well about the lack of this.

LADY SMITH: I suppose the sort of pack you have in mind, Jo, isn't going to be very helpful for a child whose first language is British Sign Language.

DR GREENAWAY: Precisely, yeah, yeah. And I think that can be an issue, but also for children who may see -- may understand something in one context but don't -- aren't able to then take it to another context, or for children whose memory fluctuates. So there's a great variety of needs and that's why it has to be quite individualised, I think. The danger is having a pack that doesn't fit all.

LADY SMITH: Job done.

DR GREENAWAY: Yes, it doesn't do that, no.

MS INNES: Then if we move on to page 44, you talk about issues of control and use of restraint and seclusion.

And in about the middle of the page, you refer to the Children and Young People's Commissioner in Scotland in 2018 investigating the use of restraint and seclusion in schools, and it found that the information provided by families suggested that restraint and seclusion was

used disproportionately with children with disabilities or additional support needs.

And whilst you say this report doesn't identify whether families were referring to residential schools, it is about education settings. You do also then, just towards the bottom of the page, refer to the Care Quality Commission reporting high levels of seclusion and restraint in specialist units for people with learning disabilities and autism. So there appears to be a widespread base of evidence across the UK that children with disabilities or additional support needs are disproportionately affected by restraint and seclusion.

DR GREENAWAY: Yes.

PROFESSOR FRANKLIN: Absolutely, and that's replicated across international evidence as well.

Q. And so, for example, at the top of page 45, you refer to the Children's Commissioner for England reports in 2019, which detailed the experiences of autistic children and young people who had learning disabilities staying in mental health hospitals:

'Staff spoke of using physically restrictive measures as a matter of routine.'

And then it goes on to reflect on the experiences of young people in terms of being restrained. And then you

also go on to refer to the same report, which also found examples of the use of chemical restraint?

DR GREENAWAY: Yes.

Q. And you then, below that, refer to a work by Pinney in 2017, raising concerns about the appropriate use of chemical restraint. So what sort of concerns were being raised about the use of chemical restraint or sedation?

PROFESSOR FRANKLIN: I think it's, again, there's multiple factors at play here. So we've got the overuse of chemical restraint with this group of children and young people. We've got issues around it being used as a matter of routine in order to -- because we've got the staff that may not necessarily be trained or it's become a culture where restraint is used because people are not necessarily understanding that communication, or a child's behaviour is communicating something. So restraint and chemical restraint is used as a way to control behaviour.

DR GREENAWAY: Rather than de-escalation techniques.

PROFESSOR FRANKLIN: Do you want to say anything more about de-escalation?

DR GREENAWAY: Yeah, de-escalation, really, rather than resorting, first line, 'Oh well, they've got a prescription for ...', you know, 'Let's just give them ...'. And I think it's quite difficult, isn't it,

because we -- the reports aren't very specific about stuff, are they, so ...

PROFESSOR FRANKLIN: Yeah, I think there's challenges around what we mean by 'restraint' as well, so actually even if we have statistics, and I know there's been the Care Inspectorate report on restrictive practices recently in statistics. It's what do we mean by 'restraint' or 'seclusion'. Those terms are used quite interchangeably in different circumstances. But what you can find across the evidence is the increased use of restraints with this group of children and young people, in order to manage children who are traumatised and are trying to communicate things.

I think the other thing that you will find as well with the New Zealand evidence that was given was the use of chemicals and over-medicalisation of this group of children, so there's particular examples there of children and young people being constantly medicalised, and using anti-psychotic drugs and tranquilisations with this group of children. And you also see evidence in there of disabled children being given chemicals, for instance, to stop their menstruation cycle.

So there's examples where kind of chemical restraints or chemicals are used specifically for this group of children maybe in different ways than they are

used with non-disabled children.

Q. Okay.

And if we go on to page 46, under the heading 'Impact on children and failures in monitoring', you refer to the Challenging Behaviour Foundation report from 2020, which gathered evidence from parents of 720 disabled children across the UK and, within that, parents described the impact of restraint and the ongoing effect of that in relation to their children?

DR GREENAWAY: Yes, yeah.

Q. What was this report looking at? I mean that's one of the aspects of it, but was it a broader study in relation to the experience of disabled children, or their parents or --

PROFESSOR FRANKLIN: So the Challenging Behaviour Foundation was -- it was a survey that was administered to parents of disabled children, so it was self-selecting for parents to take part. And the evidence we've presented there was questions that particularly related to the impact of routine, continued restraints, you know, of those children and young people. So it was very much trying to platform the experiences of families around the use of restraint and seclusion for disabled children in different settings.

DR GREENAWAY: And actually it was entitled 'Reducing

restrictive intervention', so, you know, it was collecting the data but then going: what can we do about it? So that was the focus.

Q. And then at the bottom of the page you refer to, again, the Children's Commissioner for England report in 2019, and this was in relation to children with learning disabilities or autism living in hospitals.

And then there's a description there of children being secluded in stark, bare rooms and environments which made them feel like prisoners rather than patients. That was something particularly highlighted in that report?

PROFESSOR FRANKLIN: Yeah.

DR GREENAWAY: I was going to say, we know this is not just happening in hospitals, it's happening in schools. Recently, is it Whitehead School, that's been publicized? And unfortunately it's happening, it's still happening, it's happening in lots of different areas where disabled children are, but I know that the focus is on residential, but you see it's happening in schools, it's happening in hospitals.

PROFESSOR FRANKLIN: And I think the challenge is, it's around understanding -- we don't know, as yet, the extent, the frequency, the reporting, the understanding, of why this is being used. So I think it again lends

itself to the fact that we have limited data on this. But all of the evidence suggests that in settings where there is a good understanding of the needs of the disabled child, you understand the communication, you understand how to support that child, that in those settings where all those things are in place, there's no need for the use of restraint, because they're de-escalating the situation, they're understanding the child's needs. There's no need for things to escalate because restraint should only be used in very, very specific circumstances under law. And if it's becoming a matter of routine, that's an indication that something's going wrong. And I think that's an important point, probably, to make.

Q. And now if we move on to page 49 and to the heading 'Closed systems and lack of external challenge'. This is what you mentioned just before the break. That a key issue in the Hesley abuse scandal was that the setting provided education and care together and you said that there were issues in terms of a lack of coordination between the staff, but you also refer here to this being a closed setting with little external challenge to poor practice from outside agencies. Can you tell us a bit more about this and what was highlighted in Hesley?

PROFESSOR FRANKLIN: I think this is really important to

sort of unpick, because for many of those children, they were placed a long way from home and we do find that with disabled children, they are placed in institutions that can be isolated a long way, so there's a lack of external scrutiny.

So by 'closed cultures', what we mean is that there isn't that outside observations, I suppose, or outside scrutiny of what's going in or going on within those setting, and that clearly was the case with Hesley, where children were placed from local authorities all over England which made it very difficult for the placing authority to monitor the situation that was happening in Hesley. And it means that, you know, it's of great expense and difficulty for families to be able to visit their child in those settings as well, because, you know, some of those children were 200 miles away from their home.

So what it does is it creates an environment where there isn't that outside scrutiny. So obviously abusive practice can start and escalate and become the norm, because there isn't any outside scrutiny. That's not to say people within Hesley didn't raise concerns, they did, but they weren't followed through. But it's that closed-off nature of these children in a place a long way from home, where they're educated and they're

living, so we don't know what's going on behind those sort of closed walls is kind of what we mean by that.

DR GREENAWAY: And although there was some independent advocates going into Hesley, it wasn't widespread at all. I think the majority didn't have an advocate, an independent advocate to communicate with them or to support them to communicate their needs. And that's one of the recommendations of the Hesley report, it's about independent advocacy.

PROFESSOR FRANKLIN: And I think the other thing that Hesley raised as well was because it was a closed setting without external professionals going in, there wasn't the ability for staff within there to be able to not only raise concerns, but also reflect on their practice. Because again, unless you know what's going on outside your own walls, how can you know whether what you're doing is good practice? And that comes back to the question you said about leadership as well within the setting, because the poor leadership also wasn't communicating with the placing local authority. So it's sort of a breakdown in terms of scrutiny and understanding and reflective practice and actually looking at what's going on within a setting when it's so closed.

Q. And I suppose if a child's not going to school, you

don't even have -- well, school outwith the setting, you don't even have teachers or other people who are unconnected with the setting, meeting that child?

PROFESSOR FRANKLIN: Absolutely, and I think what's important to mention with Hesley, the children in Hesley, they were children with complex needs. They were children with communication needs. They were autistic children. Those with learning disabilities. So if you haven't got somebody seeing the signs or indicators of abuse, then who's going to notice what's happening? And that was another reason it was allowed to continue and flourish in that setting, because there wasn't that external scrutiny.

Q. And you mention that the Children's Commissioner for England in 2019 raised similar concerns about accountability within mental health hospitals, because they were also closed-off. Can you tell us a bit more about that?

PROFESSOR FRANKLIN: So that particular report was looking at autistic young people and young people with learning disabilities within hospital settings, so again they are closed settings, the children were in there -- I mean, some of the children in there were in locked rooms. You know, again it isn't that external scrutiny unless there is, the child has a social worker, not all of them would

have social workers. If they're placed a long way from home, the family aren't necessarily seeing the child either. And, as Jo said, often in those settings they may not have, the child may not have an advocate, for instance, so there isn't the opportunity for practice to be noticed or highlighted. So it's -- as Jo said, it's happening in multiple settings.

Q. You also highlight at the bottom of the page that the same staff would be involved in medical care as well as essentially managing the children's social lives?

PROFESSOR FRANKLIN: Yeah. Some of the settings that the Children's Commissioner went into again, you know, the children and young people are in there for very long periods of time and again that comes down to the fact that there's not resourcing or investment placed in actually providing other services, so that they don't have to be in those medical settings. There's evidence that they shouldn't be in those settings in the first place. But because of that, children are there for long periods of time. They are receiving their education there, as well as other services, so again, that outside scrutiny is hard to manage.

Q. Then at page 50 you go on to refer to staff recruitment and workforce issues. So again, Hesley and the 2019 report, you highlight the changeover of staff and

I think also the high use of agency staff was highlighted in the 2019 report, and what particular issues can this raise for disabled children?

DR GREENAWAY: Well, we talk about sort of individualised communication, for example. If you have a high turnover of staff getting to know that child and how they communicate and for the child to feel comfortable to be able to communicate in their own particular way, or to -- that relationship building is even more challenging for the child. That's just one example, really, isn't it.

PROFESSOR FRANKLIN: I think another example is if you are a disabled child and you need personal care then if you have got a turnover of staff who are, you know, giving you personal care then that understanding of who is and who isn't allowed to touch your body can become very blurred, because you have no control over who is in your personal space and who is touching you for personal care. So if you've got a turnover of staff and -- in Hesley I think it was 39/40 per cent during a three-year period -- you've got children there who need support with their communication, who need support with personal care and you've got multiple staff coming in, that's creating increased risk and an environment where children and young people don't have any control or

agency.

So I think it's really important to highlight that staff turnover. It was a factor, I think.

Q. Okay.

And then if we go over the page to page 51, we see issues about training, which we've already touched on in your evidence. But at the bottom of the page, you then refer to attitudes and values held by staff in settings, and you say:

'These shape the culture of care and significantly influence the safety and well-being of disabled children.'

And then you go on to say that you look at:

'UK and international evidence to explore how staff values and disablist attitudes can contribute to cultures of harm and considers the importance of values-based practice in preventing abuse.'

And then if we go on over the page, you talk about, for example, dehumanising behaviours that you have already mentioned in your evidence, and this can arise from disablism. Can you expand on that a bit further in terms of you talked about training. From what you're saying, it's not just about training, it's also about staff having the right values and attitudes?

PROFESSOR FRANKLIN: Absolutely. Absolutely. And that

comes clearly through the evidence that there can be a dehumanising aspect to the way that some people view disabled children and young people. And sometimes it can be that they just see the disability and they lose sight of the child, but some of it is around a value system that underpins our attitudes and values towards disabled people and disabled children and young people, and seeing them as inferior, or not necessarily needing, you know, a right to support.

So I think there's prejudice, there's stereotypes, there is a value base to a lot of what we're finding here, where we're not seeing disabled children as humans, as children, and that can impact on the types of staff and the way that support is delivered in those settings.

Q. I think, if we go down on page 52, you quote from the Lenehan review in 2017, referring to, for example the Winterbourne View:

'Instances of sexual exploitation of children have reminded us that when we believe the people that we interact with are less than fully human, we build a culture which leads to degradation and abuse.'

I think you are highlighting that this is a particular risk if you have staff in a setting who have disablist attitudes, then that could then lead to

a culture in which abuse can occur?

PROFESSOR FRANKLIN: Absolutely, yes.

Q. I suppose as well, as you have said, that goes beyond training. So that's about recruiting people and identifying what values they have?

DR GREENAWAY: It's community values, isn't it, it is a culture, it's societal values as well.

Q. And then I suppose once somebody is in an institution, creating the right culture so that people do call out attitudes that are not conducive to the welfare of children?

PROFESSOR FRANKLIN: Absolutely, and I think that's the danger with closed settings, that if there are cultures and values within those settings that aren't called out, also it goes back to leadership, that if there isn't an environment that creates -- a leadership that doesn't create an environment that supports staff, children, others to raise concerns when they are seeing these sorts of values and attitudes, then again we are doing a disservice to those children and young people. And we see this, we see this throughout all of the evidence; that those sorts of values, those attitudes, underpin prevention work, response work, you know, placements, the value we are placing in terms of resourcing, it underpins so much of this evidence, actually, that we

are given.

Q. And I think you continue in relation to that theme over the page on page 53. You highlight some of the outcomes of the New Zealand Royal Commission at the end of the first paragraph, highlighting that disabled people were not seen as valuable members of society. They were placed out of sight, out of mind. And then also issues that they highlighted in relation to deaf children and parents being told they should be institutionalised, essentially?

PROFESSOR FRANKLIN: Absolutely. I guess -- I think that's what the New Zealand Royal Commission did; was it highlighted that there was a pathway, almost an expectation, that this group of children and young people should be placed in the institutions in order to, you know, treat, give them treatment, support them to become active citizens in society, and I think that value base underpins some of these values, and it goes back to the point we made even about research. I mean, I have applied for funding for research and had funding refused because 'abuse doesn't happen to disabled children'. And you think gosh, where do you go with that?

DR GREENAWAY: Or that's just a small, very small cohort of children and it's like, but actually we are not valuing

children in terms of their cultural identity, their needs, but also them as unique people. And, sorry, we are going to get passionate about this, but that's something that we are really passionate about, but it is something that isn't really out there, obviously, and that's why this sort of thing ... in my mind, this is why it's -- not allowed to happen but is more likely to happen, because disablism, ableism, it perpetuates the attitude that it is okay to or it doesn't really matter, it's not -- you know: do we need to do that? It is minimising, it's making things inferior, it's -- yeah, I could go on. Sorry.

PROFESSOR FRANKLIN: It's so important and it's still prevalent today. Our most recent report that was actually around exploitation, but there are quotes in there from practitioners saying, 'You can be disabled or you can be exploited, but you can't be both', and what they are trying to get at here is the way in which people are valuing and seeing things, but also the way in which services are constructed as well, because you will go into a different service and they won't necessarily see the combination of needs.

DR GREENAWAY: Labels are helpful but they can also be destructive and unhelpful.

Q. If we move to the bottom of page 53, you start talking

there about the power and voice of disabled children within residential settings. And you say that they often lack power, control and a means to voice their fear, harm, be seen and seek help.

You say:

'Within the available evidence, there are repeated accounts of children being silenced, whether through inaccessible communication systems, poorly trained staff or staff that fail to listen and respond.'

So if you carry on to the bottom of page 54, you note:

'The Hesley Review starkly illustrated the lack of power and control for this group.'

So they had a lack of voice in their everyday lives and in decisions taken about their care as a whole.

So if children aren't involved in sort of decision making on a day-to-day basis, how does that then impact on their ability to communicate or to have agency?

PROFESSOR FRANKLIN: And that goes across everything, because actually if you are not empowered or taught how to speak up around everyday issues, how are you then going to voice, if you can, and we're not expecting children to disclose abuse here, but how can you indicate harm? Or if you're scared? Or have some sort of power or agency over yourself? If you haven't been

encouraged or supported to be able to speak out about everyday issues, let alone the more challenging and difficult issues. If children can speak out about these things.

DR GREENAWAY: It's not just about speaking out or being able to articulate or ... it's about that being acknowledged and acted upon, is the really important thing, that means that that child then has a sense of value in what their feelings and their understanding of things is actually valued by the person or people who are responding to what they're communicating and that's a really important thing, I think, isn't it?

PROFESSOR FRANKLIN: And I was going to say that there is evidence throughout this of children's access to communication being taken away as an abusive act. So there is something there about the specific needs of those children, and their need for communication being used against them. So I think that's an important point to mention. And I think the other important point to mention is the use of advocates. And the fact that for many children, disabled children and young people, having access to an independent advocate isn't guaranteed, or having an advocate with the skills, training and knowledge to be able to work with disabled children can also be an issue.

So, rightly so, there's a big call for use of advocates to support and be a mechanism for external scrutiny and a mechanism for children to be able to have their needs and voices understood, but without that support, that training, to understand that communication.

DR GREENAWAY: Yes, an advocate has got to be well trained and be competent in communication skills, or willing to learn that particular child's communication skills to be able to be effective, really. So a tick box that says 'Advocacy' is not necessarily the be all and end all, but it could be a very powerful tool.

Q. Yes, you deal with this on page 56, and in the final paragraph on that page, you mention that:

'It is important to note the significance placed on defining these children as too challenging for visiting professionals, such as social workers, to see the child alone and without staff in the setting present.'

So it looks like members of staff were saying, 'Well, I need to be there in order that you can communicate effectively with the child'?

PROFESSOR FRANKLIN: That was the case in Hesley and it's been my own experience in undertaking research sometimes in institutions, where, you know, it's been deemed that these children are too challenging for independent

people to have access to, but also to have time to spend with, to understand a child's presentation, or how they behave, or how they communicate, or actually having time away from staff who, you know, in the Hesley case could have been the potential abusers. So it's -- again, it's the nuance of the child's needs being used as a mechanism to prevent scrutiny and outside visitors to be able to communicate or spend time directly with a child.

DR GREENAWAY: This is the argument, that having yet another professional coming and visiting a child might be detrimental, that's an argument that can be used. But on the other hand, so from a professional's point of view, if they don't understand how that child, or they find it difficult to communicate with that child, or understand the communication the child's presenting, that is also a challenge for that professional, it's not the child's issue, it's the professional's issue, but it takes time. So as a social worker, I know that it will take me a lot longer to build up a relationship and understand the individual communication of a particular child if they have complex needs than one who may be quite articulate and able to, yes, because you spend time to get to know the child that you are working with, but it takes so much longer. But, of course, if you've

got the pressure of resourcing and time and money for your visit to 200 miles away to wherever it is that that child's placed, it all adds up to the impact on the child and their voice.

Q. If we can move on to page 57, where you go on to look at 'Inadequate external monitoring, scrutiny and national policies' and one of the issues which has arisen in the reviews was poor communication between agencies, so that's to do with a failure to share information appropriately, and then, if we go on over the page to page 58, at the bottom of the page, you have a heading 'Lack of action by oversight bodies', and in Hesley there were outside bodies involved in monitoring what was going on, but why did the abuses not come to light through that inspection process?

PROFESSOR FRANKLIN: I wonder why. I don't -- I can't answer why those things weren't followed up. I think what's important with Hesley is that they highlighted that Ofsted had received complaints and information on potential abuses in that setting for a number of years, and I think that what they highlighted was that although that led to increased monitoring visits, the setting was still rated as good.

So I think that's raising concerns and issues about the inspection process, but also about the way that

information is received, understood and acted upon by those inspection services. And some of that may come back to the fact that particular training around disability could potentially be lacking in some of those inspectors, and the understanding of that particular setting, if there's generic inspections going on. So I think there were issues around that.

And I think as well that the other thing that Hesley did was to highlight in this particular cases the role of LADOs, the local authority designated officers. So they have a responsibility to look at abuses by staff within their settings, so the LADO's role -- within a local authority -- so the LADO's role in Hesley's case, they should have -- would have received information regarding children from multiple local authorities, and there seemed to be some sort of breakdown in communication between the LADO in the local authority where the setting was placed receiving the information from multiple local authorities and combining and collating that evidence to show that there was a problem within the setting. If you think of it as individual children, then you are not going to think there is a problem within the setting.

So I think there's a number of actions, a number of, I suppose, systems, or processes, that Hesley drew

attention to where there were failings at different levels to bring information together and scrutinise and action.

Q. Yes, so at the top of page 59 you go on to refer to the LADO and Hesley, and you say there would have been the one where the setting was based, but then there were 43 local authorities who had children placed at Hesley and were aware of concerns, but nobody was actually drawing them all together?

PROFESSOR FRANKLIN: And I think it's important to, where LADOs work, they work well, because they are very good at drawing that information together. However, we do know that in England, LADOs are incredibly underresourced, and to gather that information, to liaise with, in this case I think it was, what was it? 43 local authorities, to bring that evidence together requires resourcing, training, understanding, and proper scrutiny. And I think the LADO's role is important when it works well, but often that is dependent on the information that they're receiving. So if it's good quality information that can be brought together, then, of course, you can highlight issues. But sometimes it depends on the quality of the concern -- the way in which the concern is being raised.

So sometimes it can be about quality. It can be

about quantity and resourcing in order to be able to deal with that appropriately. But obviously in this case, the Hesley case, there was a huge failure, if 43 local authorities were reporting concerns.

Q. You go on to refer a bit further to the LADO role on page 60 on the bottom of the page, again because they had failed to act on the increasing and significant number of allegations. Would a LADO be one person or would it be an office of people within a local authority, or does it vary?

DR GREENAWAY: My experience of it being one person that may designate a task to other people, for example, if a child's got a social worker and a report's been made and the child's social worker has got a relationship with them, that they might be the one that sort of first then talks to them on behalf of the LADO, but that's my experience. I'm not -- I don't have a broad view of the whole of England.

PROFESSOR FRANKLIN: It's my --

DR GREENAWAY: Sorry, go on.

PROFESSOR FRANKLIN: It's my experience that they're underresourced across local authorities and it could quite often be one person dealing with lots of information from multiple sources.

DR GREENAWAY: And I think it's also worth pointing out that

a LADO might not necessarily have the experience, understanding or training specifically in communicating directly with disabled children and young people with complex needs, and so you have non-verbal children, there's been complaints like with Hesley raised, you know, it's about that LADO feeling confident to being able to go themselves, or understand what's happening for those children and young people rather than relying on other people.

Q. Yes, so they would need to identify people to assist them in a task if you have got, for example, 43 local authorities expressing concerns, or identifying somebody that's going to help them investigate further in relation to the particular setting?

DR GREENAWAY: Yeah, yeah.

Q. Just bear with me a moment.

If we go on to page 61, and towards the bottom of the page, you note again that Hesley had highlighted complexity within the system and a lack of accountability.

'The review goes as far as saying it's a confusing maze of expectations, roles and responsibilities, which can render the children at the centre invisible. No one body or agency had an accurate picture of what was happening and there were unacceptable delays in the

robust decision making that was required.'

Then you go on to refer to, for example, the Scottish Independent Care Review, which raised concerns about an overly complex and fragmented monitoring and regulatory framework for residential care settings, so that sort of mirrors the concerns raised by Hesley?

PROFESSOR FRANKLIN: Absolutely. And I think -- I mean, the other reports are talking generically about the children's -- children in care, and the social care system. I think what Hesley did was also identify that there's additional complexity for disabled children, because again there's another layer of agencies involved in disabled children's lives that is unique to that group of children and young people, so it adds further levels of complexity and further -- there's further legislation and guidance specifically for disabled children. So the other reports were talking generically about children within social care. We would highlight the complexity that's increased because these children are disabled, and it's a fragmented regulatory system around them.

DR GREENAWAY: You have healthcare and education with a high level of reporting. I mean, if you take a child who has complex needs, they might have speech and language, they have occupational therapy, physiotherapy, dietary, they

have all sorts of people involved, just on the medical setting, and then who -- they might be seen by somebody, but where do they go to? But also then you take Hesley with the 43 local -- 43 local authorities is just massive and trying to build that into evidence, you know, you can understand why there was things missed, but actually that's not good enough, is it? So it's about streamlining, I guess. That's not my role.

Q. Then if we move on to page 64, you highlight the final area of risk factors there, specifically related to disability. And I think you've already highlighted some of these issues in your evidence, but, for example, impairment-related vulnerabilities, so for example being reliant on staff for intimate personal care needs and issues with communication that you've highlighted.

Then at page 65, you refer to Hoffmann drawing attention to the fact that the longer length of time a child is in an institutional setting, particularly closed settings, the risk of abuse increased simply because there were more opportunities for abuse over time and you've already said in your evidence that children with disabilities may well remain in institutional care for a longer time, potentially even into adulthood.

DR GREENAWAY: Yes.

PROFESSOR FRANKLIN: And are entering those institutions at a younger age. I don't know if I said that before, but absolutely that was the evidence that particularly came out. In Hesley there were children as young as 9 in that setting. In the New Zealand evidence, children were being placed in institutions for deaf children and for people with learning disabilities from a very, very young age, with an expectation that they would probably spend their life there.

Q. Then you go on in the next section to look at some preventative measures that could be taken. At page 67, for example, at 3.3.1, you highlight that prevention from children going into residential settings in the first place would be a desirable outcome, but that would require additional and early support for families?

DR GREENAWAY: Yes.

PROFESSOR FRANKLIN: That absolutely came out of Hesley as well, in the fact that they specifically identified a number of children in that case of 108 children that they looked at where those children should not have been in institutional care, or in that setting. If their needs had been met within the family, within the community, there was no need for them to be there, or for them to be placed so far away from home. So there's a lot of evidence about the need for early support,

support for families, particularly around communication, and support for their child which would actually, if that was given and resourced, would mean these children weren't in residential settings in the first place.

LADY SMITH: What about the part to be played by respite care? And I take exactly what you're saying about the initial focus needing to be on family and keeping the child at home if possible, but we know that, particularly with the demands of looking after significantly disabled children, the family might need a break.

PROFESSOR FRANKLIN: Absolutely.

DR GREENAWAY: Absolutely, yeah.

LADY SMITH: But that means, does it, that the respite that's to be provided has to have all of the protections and preventative mechanisms in it that full-time residential care will have?

DR GREENAWAY: Absolutely, yeah, I mean, I think there's also short breaks. Yes, it could be in residential-type settings.

LADY SMITH: Yes.

DR GREENAWAY: But it could be kinship carers.

LADY SMITH: Yes.

DR GREENAWAY: It could be short breaks, as in foster placements, so there's different ways of doing short

breaks. And even the provision of an afternoon during the holidays can be a short break for a family. So there's various ways of doing short breaks, but absolutely. But those are lifelines for families. But if the funding's not there -- sorry, I'm going to get my two penn'orth in now, but actually if it's not resourced.

LADY SMITH: And it's not just the fees. If you take respite foster care, for instance, that are involved, it's seen to it that the person who is a respite foster carer has the regular training and refresher work that they will need --

DR GREENAWAY: Absolutely.

LADY SMITH: -- particularly because they're not doing it all the time, and they will need particular help.

DR GREENAWAY: Yes, absolutely.

PROFESSOR FRANKLIN: We know there's a shortage of foster carers for disabled children, because there isn't that support actually around the foster carer either, and to be able to provide this additional support.

LADY SMITH: Yes.

PROFESSOR FRANKLIN: But I take absolutely your point that if short breaks or respite care are residential, they absolutely need to have the same protections and support around any residential setting for disabled children,

the children may only be there for a few nights or not, but they're still there in that situation. And we weren't able to find any evidence that had specifically looked at that issue, but we cannot assume that that doesn't mean abuse is not happening in those situations, in those settings, we just couldn't find --

DR GREENAWAY: It wasn't within our remit, I think.

PROFESSOR FRANKLIN: Well, it wasn't within our remit, but we couldn't find it anyway in terms of the evidence that we've looked at.

LADY SMITH: Nor does the fact that it may be short term justify toleration of higher risk.

PROFESSOR FRANKLIN: Precisely.

DR GREENAWAY: Absolutely, yeah.

LADY SMITH: Thank you.

Ms Innes.

MS INNES: Thank you, my Lady.

On page 68 you highlight that another preventative measure would be improving provision in schools and preventing school breakdowns.

DR GREENAWAY: Yes.

Q. And again, you refer to Hesley at end of the first paragraph under this heading. You say:

'Given the higher rates of exclusions and disproportionate number of children with SEND or

additional learning needs that are excluded, this is a major concern.'

That's from recent statistics from the Department of Education, showing that children with additional support needs are disproportionally excluded from school, is that right?

DR GREENAWAY: Yes.

So just to clarify, really, we have a continuum of really, from children with very complex learning, medical, health, care needs, and you also have sort of something at the end, I don't like to call it a spectrum, but it is, really, children who have additional needs, dyslexia, dyspraxia, some mild learning disabilities, that mean that they may be in mainstream school, but that their needs are not met fully within that, and that's what the report is based on, isn't it, the exclusions from mainstream schools.

PROFESSOR FRANKLIN: I think the impact, so the impact of exclusion or school breakdowns for children, there's an absolute risk that follows that, that those children will then be placed in a residential setting.

And by that I mean if a child's excluded from school, it places increased pressure on the family, so you do see increased family breakdowns of children who have -- disabled children who have been excluded from

school, because these children have got to be home schooled, it also means -- or found another placement.

It also means as well that for when there's school breakdowns, particularly for children who may be in special schools, they can be placed in other settings, and so there's an impact there in terms of them moving, multiple placements and multiple settings, which can increase trauma and, you know, a child's anxiety, et cetera, et cetera, which again we know has a direct link to increased risk within those settings, if their needs aren't well understood.

So you can see immediately this sort of breakdown of leading from a lack of good educational provision for these children.

Q. You say over the page on page 69 that:

'Hesley highlighted that educational breakdowns were often attributed to the child --

PROFESSOR FRANKLIN: Yes.

Q. -- rather than systemic failures, and the need for improvements or changes, so it was kind of seen as the child's fault?

PROFESSOR FRANKLIN: Absolutely, it was the child that had 'challenging behaviour' or were too difficult to meet their needs within that setting. And so absolutely, you see that repeated language of it was the child that was

the problem rather than the setting adapting and meeting the needs of that child.

Q. Now, if we move on to page 72, in about the middle of the page you note that:

'Hesley [called] for mandatory training covering [certain] areas: communication, behavioural support, trauma-informed practice, appropriate use of physical restraint [and] clinical competencies to meet complex healthcare needs and safeguarding of disabled children.'

Then it goes on to also refer to cultural intelligence and understanding of racial stereotyping and cultural bias, which you've highlighted already. And you say:

'We would add to this understanding of disablism and of children and disability rights.'

And this goes back to you need to have a values-based workforce?

PROFESSOR FRANKLIN: Absolutely. I think, as you say, you can teach someone how to communicate, maybe, but actually, if they don't value the child that's in front of them or see them as having a right to communication, then it doesn't matter what tools you provide someone with, they are not going to use them, or they are not going to use them in an appropriate way if they devalue the child that's in front of them.

DR GREENAWAY: When you consider a child, a child is not there in isolation, it's a combination of their family history, of their culture, of the community that they are from, from their friends, from their relationships with other people, and all those make up the child. But if the child is just seen as just somebody in front of them, it dehumanises them as a person and their identity as a whole.

Q. If we move on to page 74, and to the bottom of the page, you note that Hesley called for a long-term national strategy for disabled children, and this was to ensure better working between agencies and partners. Was that followed up?

PROFESSOR FRANKLIN: No, is the short answer. It formed part of the recommendations, but so far many of the recommendations haven't been followed through.

DR GREENAWAY: There was some move with the Law Commission looking at disabled children and also there's been some work on advocacy, but you know, it's been piecemeal, basically, and not necessarily a response to the recommendations of the Hesley Review, but things that have been going on anyway, so.

Q. Okay.

And then going further down page 75, you highlight finally in your report some gaps in knowledge and

understanding and how these could be addressed, and we've touched on a lot of these as you have gone through your evidence, so, for example, at the bottom of page 75 'Recognition and definitions of disability' and then building on that to have the appropriate data.

If we go to the top of page 76, you say:

'We would argue that sometimes it is a case of data not being adequately scrutinised through a disability lens.'

And you refer back to the Care Inspectorate reviews that we talked about at the beginning of your evidence.

So if you don't have that data at the start, you then can't undertake the research?

DR GREENAWAY: Yes.

PROFESSOR FRANKLIN: Absolutely. I think it's just really clear that if you don't have a disability focus, or you think with a disability lens, then you don't see these children. And I think that threads its way through. Because if you don't think of it, then you will look at a data set and you won't think to identify the disabled children within that data set. And we see it time and time again. We look at studies and we think, 'Great, they're looking at this', and then they haven't analysed it at all in terms of disability.

DR GREENAWAY: A little footnote at the bottom of, 'This

also affects disabled children' or ...

Q. At page 78 you talk about the lack of voice of disabled children, and I think this is in research. I think that this is an area that you've worked in, particularly, probably both of you have worked in the inclusion of the voice of disabled children in research.

DR GREENAWAY: Yes.

PROFESSOR FRANKLIN: Absolutely.

That's not without its challenges, I've already mentioned funders don't necessarily see the value of that. They don't necessarily provide enough resourcing for you to be able to do that in accessible, ethical ways, because that takes a bit longer to do. But I see so often that disabled children have been excluded from studies, so I think there's an onus as well on the research community, academia and others to change their practices as well around making their methods accessible for disabled children.

Q. Then on page 79 at the bottom of the page, you talk about 'Gaps [in] case reviews and the availability for independent scrutiny and accountability'. And I think you are referring there to difficulties in even accessing reviews, not all of them are published?

PROFESSOR FRANKLIN: No.

Q. And that goes for England and Scotland?

DR GREENAWAY: Yes.

PROFESSOR FRANKLIN: Yes.

Q. And how do you think that could be resolved?

PROFESSOR FRANKLIN: I think there's a willingness to make sure that these reports are accessible and available to the public. I think there's something there about the value we place on following these things through, so that we can make sure that we are learning from it. I do take the point that sometimes there are criminal investigations going on in these settings that may mean you can't make access, public access, to some of what's going on. But we are talking about things that happened years ago, and so therefore there's something there about are we following through what's happening with these children, and young people, and we were really, really surprised at the lack of serious case reviews that we could find around disabled children.

DR GREENAWAY: Despite knowing, you know, the scandals that have happened, just the lack of inquiries or evidence.

PROFESSOR FRANKLIN: And I think again it comes back to how disability is recorded. So if you try to search for serious case reviews, or significant case reviews, any of these reviews, and you are putting 'Disability' to try to find them, disability may be a footnote in the serious case reviews. And if you read them with

a disability lens, you see constantly things that should have been in place or supported the child around their disability needs, but because people aren't looking at that child through that lens, they're not necessarily seeing that.

So I think there's something there about how we also conduct these reviews to understand the complexities, the holistic needs of these children, 'cause sometimes that can be a footnote in them. So the ones that we were able to find had specifically registered, hadn't they, that these children had a disability, but that's not always the case, either. So I think it's about the value we place on how much we scrutinise and follow through and learn from what's happened in the past, and what's gone wrong.

DR GREENAWAY: And apart from 'Beth', if I'm right, the other children were able to take part, the ones that fortunately were alive, were able to take part or had been able to articulate in some way to the investigation, to the case review, but we're talking about 108 in Hesley and not one of them had been through that sort of process, and had their voices heard, apart from the inquiry itself, but yeah.

Q. Then if we just go to the conclusion of your report, so at page 86 you've highlighted the various gaps that

we've been discussing. You say:

'As we reflect on these findings, the question is no longer whether change is needed but how quickly and forcefully we are willing to act. We should not be still in a place where disabled children are not afforded the attention and protection they deserve and have rights to.'

Then you refer to the foreword to the Hesley Review, where it is said:

'It is profoundly shocking that, in the 21st century, so many children who were in plain sight of many public agencies could be so systematically harmed by their caregivers.'

I suppose adding to that: and that did not come to light despite the number of people that knew about their concerns?

DR GREENAWAY: Yes.

PROFESSOR FRANKLIN: And I think the important point is it's still happening now, and I think the Hesley is very, very recent and obviously with something like the New Zealand commission, you know, some of these people were 90 years old. So we have got a long history, and a continued, contemporary understanding that the same types of abuse and the same ways in which abuse is allowed to happen, is still happening over that long

period of time, and I think that's -- it absolutely echoes, doesn't it, Annie Hudson's, the chair of the Child Safeguarding Practice Review Panel, that we shouldn't be in that position now, should we? We should be shocked that this is happening, but we aren't, and we constantly see, you know, newspaper reports or individual sort of small children's homes being closed because of abuses within those settings. But why are we still seeing that? Why has there not been change? And I think that's why we ended with that quote, that, you know, it is shocking, but it shouldn't -- you know, we shouldn't be in that position still.

MS INNES: Okay.

Thank you very much to you both, I've got no more questions for you.

LADY SMITH: Let me add my thanks. I have no more questions, but I'm really grateful to both of you for spending your entire morning being probed by us and drawing on all your skills, knowledge and experience that have also gone in to producing this report.

Thank you so much.

PROFESSOR FRANKLIN: Thank you.

LADY SMITH: Do feel free to go and safe journey home.

PROFESSOR FRANKLIN: Thank you.

DR GREENAWAY: Thank you.

(The witnesses withdrew)

LADY SMITH: I'll rise now for the lunch break and we will be sitting again at 2 o'clock, thank you.

Thank you.

(1.00 pm)

(The luncheon adjournment)

(2.00 pm)

LADY SMITH: Good afternoon.

Now, we turn to, I think, the Mental Welfare Commission, is that right, Ms Innes?

MS INNES: We do, my Lady. We have two witnesses sitting as a panel this afternoon.

One is Julie Paterson, who is Chief Executive of the Mental Welfare Commission for Scotland and the other is Suzanne McGuinness, who is the Executive Director of Social Work at the Mental Welfare Commission.

LADY SMITH: Thank you.

Suzanne McGuinness (sworn)

Julie Paterson (sworn)

LADY SMITH: Thank you. Now do both sit down and make yourselves comfortable.

Suzanne, Julie, thank you so much for coming along this afternoon to help us with your evidence in this section of our case study hearings and, as you know, we have been looking particularly into the provision of

residential care for children with healthcare, additional support needs and disabilities.

What we particularly want to do this afternoon is talk to you about the information that you've provided to us already, thank you for that, but we'll explore some parts of it in a little more detail as we go through.

If you've got any questions at any time, please do say. If you want a break, I can assure you I'll take a break at around 3 o'clock anyway, but if you need a break at any other time just tell me.

Otherwise, if you're ready, I'll hand over to Ms Innes and she'll take it from there.

Thank you.

Questions from Ms Innes

MS INNES: Julie, if I can perhaps start with you.

Thank you for providing your CV to the Inquiry. We understand that your current role is as Chief Executive of the Mental Welfare Commission, is that right?

MS PATERSON: That's correct, yes.

Q. And you've provided your CV in which you tell us that your undergraduate degree was in psychology and you have a master's degree in social work?

MS PATERSON: That's correct, yes.

Q. And from 1995 until 2007, you worked for Fife Council in

the context of mental health social work?

MS PATERSON: Yes.

Q. And then between 2007 and 2009, you had a period of secondment at the Mental Welfare Commission?

MS PATERSON: I did.

Q. And then you returned to Fife Council, where you progressed through more senior positions until you became Divisional General Manager with Fife Health and Social Care Partnership in 2015, and then in August 2020, you moved to your current role, is that right?

MS PATERSON: That's right, thank you.

Q. And then, Suzanne, you have a law degree?

MS MCGUINNESS: Yes.

Q. And you worked for a period in the prison service before undertaking a social work qualification?

MS MCGUINNESS: Mm-hmm.

Q. And you tell us that you then worked in social work, and from, I think, 2013 to 2021, you also worked at Fife Council?

MS MCGUINNESS: I did.

Q. And you progressed through various roles, ultimately to become the Professional Social Work Lead for the Fife Health and Social Care Partnership, and then in 2021 you moved to your current role as Executive Director Social

Work at the Mental Welfare Commission, is that right?

MS MCGUINNESS: I did, yes.

Q. Thank you.

Now, you've provided a report to the Inquiry, answering several questions that were put to you, and this is at MWC-000000003, so it will come up on the screen. And we can see on the first page that you were asked a number of questions by the Inquiry, which are addressed in this report.

So if we can go on to the second page, please. Thank you, I was going to ask if we could expand it a bit, thank you.

So, you tell us there that:

'The Mental Welfare Commission for Scotland in its current format was established under the 1960 Mental Health Act and it came into existence on 1 June 1962.'

And its predecessor was something called the General Board of Control, is that right?

MS MCGUINNESS: Yes.

Q. And you say that:

'One of its primary roles in 1962 was the discharge of patients from large long-stay institutions.'

So, was that moving patients from institutions that we've heard about, like Lennox Castle and the Royal National Hospital in Larbert?

MS PATERSON: It's certainly historical settings where people lived in institutions rather than had the opportunity to live in the community.

Q. Okay.

And then you say that:

'The core focus of the Commission remains protecting and promoting the rights of people with mental ill health, learning disability, dementia and associated conditions.'

And does that cover all ages, including children and young people?

MS PATERSON: It does: children, young people, adults and older people.

Q. Okay.

And then you note that in terms of your set-up, if you like, you're an independent health body accountable to Scottish Ministers, so you're directly accountable to Scottish Ministers, is that right?

MS PATERSON: That's right.

Q. And you refer to some of the relevant legislation under which you have particular duties, and then you say at the end of this paragraph:

'We welcome the Scottish Mental Health Law Review's recommendations to extend our role and reach further.'

So broadly in what respect is the Commission's role

to be extended?

MS PATERSON: The Scottish Mental Health Law Review was a piece of work that was undertaken over a period of three years and it took account of evidence from a range of people who used mental health services: carers, relatives, people who work in the field of mental health and they completed their recommendations report in 2022. And there were 202 recommendations within that report and a number of which related to the Mental Welfare Commission, and it related to extending our role, extending our reach and strengthening our role and our powers to effect change.

So that included -- there's a chapter in relation to accountability, which lists a number of extended roles for the Commission. There's a chapter on reducing coercion, which includes a number of actions for the Commission to take forward, should that be agreed going forward, and we very much welcome that.

Q. Okay, so in terms of the extension of accountability, is that accountability of others to you, or accountability of the Commission to something else?

MS PATERSON: There's accountability over a range of recommendations within that particular section, but accountability to make sure that the Commission, we can have extra powers, potentially, to revert to court

should we need that, for us to work more closely with advocacy services, so we hear directly from people who use services about what's important to them and any concerns they have, so there's quite a number of recommendations within that specific chapter, not all about the Mental Welfare Commission.

Q. Okay, and you said this reported in 2022, to what extent have any of those recommendations in relation to the Mental Welfare Commission been taken forward?

MS PATERSON: At this stage, there's the key area that's been taken forward by the Scottish Government is in relation to the Adults with Incapacity Act reform, that's a priority in relation to particularly deprivation of liberty.

There are some areas that we've been working with Scottish Government on in order to progress some of the recommendations. So, for example, one area in particular this year we're looking at is an area that was highlighted by the Scottish Mental Health Law Review, where when somebody's detained under the Mental Health Act in an emergency situation, they should have what's called a mental health officer, who's also a social worker, to, you know, make a decision in relation to that and the numbers in relation to mental health officer consent have reduced significantly over

the years, which is really a very important safeguard and a really worrying trend.

So as part of the work that we'll be taking forward this year, linked to the Scottish Mental Health Law Review, we'll be looking at that, monitoring it and trying to understand why that's happening. So there are some aspects of the Mental Health Act Law Review that we are taking forward, but not the key aspects to extend and develop our role in the way that we would hope.

Q. Okay. And why is it that those recommendations into the extension of your role and powers haven't been taken forward so far?

MS PATERSON: I think it's about priority in relation to, you know, what -- there are 202 recommendations within the Scottish Mental Health Law Review, so in terms of the laws, in terms of people's rights, the AWI reform has been deemed to be the priority at this stage.

Q. Okay.

LADY SMITH: And when you say AWI, you mean the Adults with Incapacity legislation?

MS PATERSON: Apologies, my Lady, yes.

LADY SMITH: No, it's fine, I know what you mean, thank you.

MS INNES: And then you go on to say that:

'[You] are governed by a board which sets strategic direction for the Commission [and] board members bring

a wealth of experience in using and managing mental health and learning disability services.'.

Is the membership of this board determined by legislation?

MS PATERSON: The members of the board are appointed by the Scottish Government. In legislation, we certainly are required to have at least one person on the board who's got experience of -- as a carer of somebody who has experience of mental illness, learning disability, a dementia-associated condition and also we're required to have somebody on the board who has experience of using mental health services too.

Q. Okay.

And then you say:

'We operate as an independent voice working across the age range [as you've said] from children to older adults and are regarded as a watchdog.'

Why do you describe yourselves as a watchdog?

MS PATERSON: We're described as a watchdog, we are not an inspectorate, we are not a regulator, we do not measure against standards and we have no powers of enforcement. So, for example, the Care Inspectorate can close a care home should they deem that necessary. We don't have those powers. Our watchdog title comes from, for example, the influence that we have. Our staff

within the Mental Welfare Commission who visit services and visit people are all qualified mental health professionals, either doctors, nurses or social workers, or people with experience of mental illness and other health-related conditions, or people who are carers.

So our staff visit people to hear, under section 13 of the Mental Health Act, what people think of their own experience within these services, and to hear those concerns. So our focus as a watchdog is very much to hear from people, their experience, and to consider how -- whether that meets the standards based on the Adults with Incapacity Act and Mental Health Act, and we also review the legal and ethical compliance, as well, in relation to the Act, so whether there's appropriate authority to treat based on the Mental Health Act and also the use of detention and safeguarding. So for example, one of our reports that we published, an Authority to Discharge, in 2021, that was a result of a piece of work where a number of people contacted us to tell us about concerns they had about lawful moves from hospital to care homes.

So we have a range of intelligence from a range of sources, whether it's families, doctors, nurses, working in the field, who tell us concerns and, as a watchdog, then we take action based on the powers that we've got

within the Adults with Incapacity Act and Mental Health Act.

Q. Okay.

Now, you mentioned there the issue of enforcement, as the Care Inspectorate have. Is that one of the areas in which your powers might be extended if the recommendations of the review are implemented or does it not go as far as that?

MS PATERSON: One of the powers talks about that we can potentially take things to court should we need to. So we don't have those powers at the moment. There was a situation in -- prior to my coming to the Commission, whereby the Commission had concerns in relation to lawful moves from hospital to an alternative setting. We didn't have the powers to take, you know, those concerns to court, but we did work in partnership with the Equality and Human Rights Commission, who are a key partner for us, and asked them to use their powers to do so.

So these are the powers that we would like, you know, should we need them. We wouldn't expect to need additional powers routinely, not by any manner of means, because we work very much in partnership with health boards, health and social care partnerships and local authorities, but in exceptional circumstances that we

need to, you know, we would welcome the Scottish Mental Health Law Review's recommendation.

Q. Okay.

And then you go on to say that your day-to-day work involves Commission officers who have professional qualifications and experience, as you've said, visiting people in specialist mental health and learning disability care settings, with power to access documents. And we'll come back to that again, you refer to that later on in your report.

And then at the end of the page, you say that:

'Much has changed in our understanding and attitudes towards and the language that we use about mental ill health.'

But you say:

'There remains continuity in that the Mental Welfare Commission has always approached its work with children, adults and older people starting with the individual first.'

Can you explain that a bit further, please?

MS PATERSON: Yeah, I think section 13 of the Mental Health Act confirms that, you know, we focus on the individuals, we speak to people to ask what their experience is and, ideally, their carers and people important to them as well. And from that, we can then

focus on the impact of the safeguarding legislation. We are less focused on the overarching governance, leadership, systemic issues. However, when we speak to a number of individuals, then systemic issues may arise. But we start from the individual to understand people's experiences first and foremost, and what matters to them.

MS MCGUINNESS: Can I just expand on that ever so slightly, just to make it absolutely clear, in terms of -- starting with the individual first, there is a triangulation in terms of the information that we gather, so we would look at local -- if it's a ward, for example, look at the local policies, look at national policies and guidance, legislation, and triangulate that, along with the individual's experience to determine to what extent people's rights are being protected and promoted, or otherwise.

Q. Okay, if we go on to page 3, you talk about how the functions are exercised in practice. And you say that there are five areas which you describe, I think, as domains. So visiting, monitoring, investigation, provision of information, advice and guidance and influencing development of policy and legislation.

And, below that, you say:

'Whilst they can function independently of one

another, they are usually interconnected.'

And then you say that:

'Information gathered in one domain might inform something that happens in another.'

And you give an example of when information is received from 'our children and young people's monitoring process which monitors the admission of children to non-specialist wards'.

So, first of all, can you explain what you mean by this monitoring process?

MS MCGUINNESS: Yeah, I can answer that. In terms of our monitoring, we have a duty under the Act to report on each of the -- whether it's Adults with Incapacity, Mental Health Act, which we do every year, including children and young people who are placed in non-specialist settings, i.e. -- I say 'children', I mean anybody under the age of 18, who will be placed in an adult setting. You wouldn't expect it, you would want them in a specialist ward. But that would not be available.

So in terms of our monitoring, we require health boards to provide us with admissions, it's an ADM2 form, and we are advised of an admission of a younger person. And what that will mean is that when the Commission receives that, we will scrutinise it, in terms of the

child's individual circumstances, if they're under 16, generally we will go and carry out a visit to that child in that non-specialist unit. It's twofold in terms of monitoring, one will encompass a visit, which kind of links into your question in terms of how do things kind of link in with each other. And then the other side, our statistical report, will receive a quarterly report from health boards which will give us a list of all children that have been placed in non-specialist settings, and we'll report on that annually.

Q. Okay. So as well as the annual report, you, if possible, will carry out a visit to the individual child who's been placed in a non-specialist ward?

MS MCGUINNESS: Yeah.

Q. Okay.

And then you say that that might trigger investigatory activity in relation to the child, and also you would look at any themes emerging from this work over time. You say in the next paragraph something you've already mentioned in your evidence:

'The Commission is not an inspectorate or a regulatory body, nor is it a complaints body as such and it has limited powers of direction.'

So these are all things that the Commission is not --

MS PATERSON: Mm-hmm.

Q. -- and I think what you've said in your evidence already is, working from the individual first, the Commission is a watchdog, essentially?

MS PATERSON: It is. And it is that -- as I've said before, it's that interface between law, care and ethics, which is that unique perspective that the Commission has with the staff who visit, because they are all qualified and trained in mental health law. And it is that value of the body's -- a body with expertise and cumulative influence based on the reporting that we do, and that influence that we have, that, you know, it does, you know differentiate us from our regulators, but we do have that intelligence and that information that we can pass to regulators, should it be within their domain. So we would work closely with regulators if we have particular concerns or areas that we think they can take forward and we can't.

Q. And I assume that you maybe have some -- do you have memorandums of understanding and --

MS PATERSON: Yes.

Q. -- memoranda of understanding with other agencies to be able to share that information?

MS MCGUINNESS: We do.

MS PATERSON: We absolutely do with other regulators, but

also really key partners, for example, the Children and Young People's Commissioner, with the Scottish Human Rights Commission, the Equality and Human Rights Commission, the Office of the Public Guardian, the Mental Health Tribunal for Scotland. So key stakeholders that we work with that we can share information with and work in partnership with.

Q. Okay.

And then on page 5, you go into a bit more detail in relation to visiting, first of all, and you say:

'The Commission is the only external body in Scotland which [visits people or] regularly undertakes visits to people in specialist mental health and learning disability NHS care settings, with powers to obtain access to individuals and their care records.'

Now, I just wanted to be clear as to what you mean here. Is the uniqueness in relation to your ability to access records, or is it the very fact that you undertake these visits at all?

MS PATERSON: We are the only organisation who regularly undertakes these visits. Obviously, you will know Healthcare Improvement Scotland undertakes some visits to mental health settings too and we are currently jointly doing some mental health joint visits as well. But in terms of our routine work, our focus is purely on

mental health, learning disability, dementia, associated conditions, so all of our work is to the, I think approximately 240 settings across Scotland, that's, you know, we will visit. We undertake approximately 150 visits per year, but all of our work is mental health only.

So those mental health settings are our only focus, and that makes us unique, the fact that we do work in partnership with all the settings and mental health and learning disability and section 13 of the Mental Health Act describes the visits that we do undertake, which are not inspections, as we said before, but very clearly about people's experience and any concerns that they have.

Q. Mm-hmm. And in terms of accessing individuals and their care records, so, first of all accessing individuals, is that -- is your access to the individual dependent on the consent of that individual, or not?

MS PATERSON: Pardon me? I didn't pick that up, sorry.

Q. So accessing an individual for a visit, is that dependent on that individual consenting to speak to you or not?

MS PATERSON: Absolutely. You know, we will be on the visits on the various units and it's an announced visit, we will give information in advance so that people know

that we're coming in the hope that relatives, other family members, other people important might attend too and be willing to speak to us.

So we are really keen to encourage people to speak with us, but of course we would not enforce our, you know, visits on those people, and, you know, our visits sometimes we'll speak to a couple of people, other times we'll speak to more people, it's very much depending on whether people are willing to speak to us or not.

MS MCGUINNESS: Can I add something, just to expand a bit, in terms of when people, because people are generally, obviously, unwell in the settings that we attend, and there's no hard and fast rule in terms of kind of when people speak to us, but what we will do, if we can't speak to like everybody, we do review the records. And that's where the other part comes in, to ensure we will still carry out that kind of watchdog function in terms of the care and treatment and the individual's rights are being again protected and promoted, we will check that, even if we can't hear from the voice directly.

Q. Okay. And then you refer to various people that you can visit in terms of section 13, as you've already mentioned. And the fourth bullet point says that:

'The Act describes the purpose of these visits are for patients to meet with a Commission visitor, discuss

any concerns they may have, for the Commission visitor to assess whether the requirements of the patients under the [relevant Acts] are being met and, when the facility being visited by the Commission visitor is one which is described in section 13(3) ...'

So that -- if we look up to the bullet point above, that seems to list a number of settings, including, for example, NHS hospital facilities, so if you're in that setting, you can conduct an assessment of the suitability of the premises in relation to those patients using them. So, is that looking to see whether -- well, essentially whether the needs of the patient are being met within that setting?

MS PATERSON: Absolutely, yeah.

Q. Okay.

And then if we go down to the bottom of the page, you say:

'The Commission undertakes four main types of visits.'

So, (1), there's local -- and you break this down over the page, so you've got local visits, themed visits, monitoring visits and guardianship visits, which relate to people who are under welfare guardianship orders, I think, is that right?

MS MCGUINNESS: Yes.

Q. If we go on over the page to page 6, you tell us towards the top of the page about local visits and you say:

'Every mental health hospital ward in Scotland is visited at a frequency informed by intelligence and experience.'

Now, that sounds a bit like what we sometimes hear of as a 'risk-based approach'. Is that the sort of approach that you have in mind when you select how frequently you are going to visit a ward, or whether it's going to be announced or unannounced?

MS PATERSON: It is a risk-based approach, it's an intelligence-led approach as well. So there's some visits where we would routinely visit annually, or routinely visit biannually. However, depending on the previous visit, and any recommendations or any concerns, might bring those visits forward, or, likewise, if we have some information through the triangulation that, you know, Suzanne referred to. So we have a telephone advice line, if people contact us and raise concerns about a particular ward or area, or if we've had other concerns from other parties, then that might bring forward a visit as well. So it's very much intelligence led based on information we gather, but also from previous visits that we've done as well.

Q. Okay. In the next paragraph you say:

'The Commission visits the three specialist adolescent units each year ... and the national child inpatient unit each year.'

So, is that different from mental health wards generally? Is there a rule whereby the Commission visits all of the inpatient CAMHS units annually?

MS PATERSON: There's other visits that we will do annually as well, and others where we will do them biannually, so children and young people's units would never be biannually, they would always be annually or more regular depending on any issues arising.

Q. Okay. And in terms, again, focusing on the inpatient CAMHS units, would these be announced or unannounced?

MS PATERSON: There'd be a combination. So as you will see from our report, 25 per cent of our visits are unannounced, or sometimes more. And the majority are announced.

The announced have benefits in that, you know, giving people advance notice that we might come, they may encourage -- might encourage them to speak to us more. We send them information in advance, photos of our staff. It alerts family and relatives to perhaps be able to attend if they've got advance notice. There's also benefits of unannounced, as well, where we attend and we see how things are without any prior notice. So

we do a combination of announced and unannounced.

Q. Okay.

Then you have a heading further down that page in relation to 'Themed visits', and you say:

'Approximately two of these are undertaken on a yearly basis.'

Depending on intelligence gathering and previous work undertaken by the Commission.

So for example, there was a themed visit to secure accommodation units with the Care Inspectorate in 2015, and there was also a themed visit in relation to eating disorder services in 2020. And that latter visit included children, although not exclusively, it also included adults I think, is that right?

MS PATERSON: That's correct, yes.

Q. Okay. And when you have a themed visit, what's the output from that visit?

MS PATERSON: Our themed visits often have recommendations. It depends on what we find. So some will have more recommendations than others. But our themed visits are undertaken because it's been highlighted to us via various stakeholders as a piece of work we should do and it will be meaningful and helpful across the board, particularly in relation to learning and what's happening in practice. So where recommendations are

made, we expect all health and social care partnerships to respond to those recommendations where relevant.

Most of the time, most health and social care partnerships would be expected for a themed visit, because it would be a national approach and we would expect responses within three months, with an action plan, which we scrutinise, we have criteria to ensure that it's a smart action plan and the actions are measurable, and then we follow up that action plan thereafter.

Q. Okay. I should have asked when I was talking about the local visits, what's the output from these? Do you publish all of the reports from these?

MS PATERSON: They are. Each one is published, and a similar approach, where there's recommendations, action plans required, and we follow them up.

Q. Okay. And then at the bottom of this page you refer to monitoring visits. And you've already given us an example of monitoring, in terms of children and young people. And if we go on over the page to page 7, this then takes us on to -- from visits, to monitoring. And if we look at the bottom, the final paragraph, you refer to the annual reports -- or special monitoring reports, that you publish in relation to particular areas. And one of these areas of work is the admissions of children

to non-specialist wards.

So just to give us an example of this, I wonder if we could look at MWC-000000007. If we can look, please, at page 4. We can see that that's the children and young people monitoring reports from 2023 to 2024. And if we look on to page 4, we can see in the summary, for example, at point 2, that you look at the numbers of children and young people who have been admitted to non-specialist hospital wards and, in this particular year, it was 67 admissions involving 59 children and young people. And then you compare that against the previous year.

And then you also consider the length of such admissions. So, generally these are short admissions but you note in this year that 40 per cent remained on those wards, mostly adult, for over a week and 12 per cent remained for over five weeks. So you analyse the length of the stay as well as the number of admissions?

MS PATERSON: That's correct, yes.

Q. And then you say at point 4:

'The admissions which were over five weeks in length involved many children and young people for whom there was no national provision of inpatient beds for their age group and/or mental health needs, these included

children and young people who have a learning disability.'

So does that point to a lack of provision for children who have these needs?

MS PATERSON: Yes.

Q. Yes. And then you say at point 5:

'This year the Commission received further information about relevant admissions in only 57 per cent of cases.'

And that's much lower than in previous years.

You go on to say that you are reviewing the reasons behind this to see why this was. So you've already told us that hospitals, for example, would tell you if a child has been admitted to an adult ward. This seems to suggest that you would then ask follow-up information and that wasn't always being responded to?

MS MCGUINNESS: Yeah, that is correct, it's not always responded to. Again, we can't compel as part of the notifications process, so we do the best that we can in terms of follow-up and seeking that information and it will be a moment in time in terms of the extant date in which the report is published, as well.

Q. And you also note at point 7:

'All of the children and young people admitted to non-specialist wards and where the Commission was

provided with further information, 16 per cent were care experienced, and looked after and accommodated.'

So that's again a particular point that you note in the monitoring report?

MS MCGUINNESS: It is.

Q. Why do you ask about that as a follow up?

MS MCGUINNESS: We are -- as we'll be where we're visiting, we are corporate parents and we have got a duty for all children in any event, in terms of being in this non-specialist setting, but particularly -- there's particular vulnerabilities around, obviously, care-experienced children. So we will always report on that, ensuring the local authorities, the Health and Social Care Partnerships and the health boards are aware, they're provided with that information.

Q. So this seems to be material or information that would be requested on a follow-up basis and not at the outset?

MS MCGUINNESS: I can't, off the top of my head, think of the form in terms of ticking that box, but I can certainly get that information.

Q. I was just wondering, you know, if it's an important criteria, why would it not be on the form that has to be submitted in the first place?

MS MCGUINNESS: Yeah, mm-hmm.

Q. I mean, it's possible that in an emergency, the hospital

might not have that information immediately to hand, but it would be helpful if you were able to give us a bit more detail on that?

MS MCGUINNESS: I will.

Q. And then you also note at point 8 that:

'Access to specialist advocacy remains limited.'

And you say:

'We are disappointed to note that in the admissions where we gathered additional information, whilst 63 per cent of young people were said to have had access to advocacy, less than 13 per cent had access to advocacy that specialised in the needs and rights of children and young people.'

Are you able to tell us a bit more about the concern about this, the lack of focus on advocacy for children and young people?

MS MCGUINNESS: Yeah, this is a recommendation that we've made previously and the Commission's kind of highlighted this at the national level, as we do in our published reports. In terms that there is a significant deficiency in specialist advocacy services for children and young people. And we continue to push forward, and influence where we can, in terms of raising the plight, I suppose, of young people who are, who cannot be offered, it's not to say that they would accept it, but

at least have the opportunity to access specialist advocacy services.

Q. Okay. So are you saying that there are advocacy services but they might be people who provide those advocacy services to adults as well?

MS MCGUINNESS: Yeah, there are advocacy services out there, but when we are looking at young people and children, they should -- it would be our preferred way forward, and for the children and young people, to have a specialist advocacy service that understands the needs of those under the age of 18.

Q. Mm-hmm, and I suppose, sorry --

MS PATERSON: Sorry, can I just add to that. We are hugely supportive of advocacy services generally at the Commission. Advocacy is so important to all the people that we work with to ensure that their voices are heard and advocacy services are independent and they're so important and there's independent individual advocacy, independent collective advocacy and the services have reduced over the years. So we've got significant concerns about the voices of those people who -- children and young people, adults and older people, who, because of a mental health condition, their voices are not often as heard. So advocacy is hugely important and we need advocacy also to be specialist, as Suzanne said,

to meet the needs of the individual people for whom they are speaking on behalf.

So absolutely, advocacy across the board, really, really, important. Really important to grow advocacy. The Scottish Mental Health Law Review recommended that too and we absolutely will continue to raise it in relation to children and young people too.

Q. Because I suppose in this setting, you may have children with particular communication needs, who would also perhaps require an advocate, as it were, with specialist skills?

MS PATERSON: Yeah.

Q. Okay.

Now, if we can go back to your report again, please, at MWC-000000003. And if we could look, please, on page 8 under the heading of 'Investigations'. And you note here that you have powers under the Mental Health Act, and under the Adults with Incapacity Act, you have powers to investigate cases where there has been a deficiency of care and treatment, neglect and/or ill treatment, or where there have been complaints about exercising powers in relation to welfare of people subject to a guardianship order.

And you say in the next paragraph that this work has various levels, ranging from activity where you choose

to undertake preliminary work or there may be cases where, for example, as you say, Scottish Government might ask you to undertake particular investigations. So what sort of information would have to come to light for you to say, 'Well, we're going to start a preliminary investigation on our own', as it were?

MS MCGUINNESS: In terms of our investigation, we've actually got -- we've got five levels of investigation. At the lowest level, it may come through our advice line, so it will be at an enquiry kind of level. And it can escalate.

So where we're getting no satisfaction -- in terms of, for want of a better word, in terms of our enquiries and ensuring that the care and treatment, neglect, ill treatment is being addressed, or it's based on all of the information. And if we remain dissatisfied, that will escalate all of the way up to a level 5 investigation, which would, nine times out of ten, probably ten times out of ten so far, would be published. And it would always have a range of national learning.

That's -- that kind of drives our decision to get to the publication at national level, when we -- because, again, it's that triangulation of our -- all of our functions in terms of looking at all of the intelligence

that comes in and you start to build a picture from across Scotland.

Q. Okay. And you say in the paragraph beginning 'Very often the Commission':

'Very often the Commission will seek to ensure that matters of concern are being properly addressed locally by taking note of the concern raised and giving guidance to individuals on expectations, particularly in relation to lawful and ethical treatment and direct the individual to local services.'

So it may be that if, essentially, a complaint is made to you, you've already said you are not a complaints body, so it sounds like you signpost the person to the appropriate complaints process, but that might still trigger some further work by the Commission?

MS MCGUINNESS: It could do. And each, again, because it's all about the individual in terms of the work that we do, it will very much depend on the situation and the circumstances. And sometimes it will be a general, it wouldn't be a matter of concern, but it would be something that we are maybe aware of, or it may be that we're not the right body to deal with that. So it will be -- and there will be kind of follow-up, but it does depend on each circumstance.

LADY SMITH: Suzanne, typically where is it that you're

signposting complaints to, that you can't deal with?

MS MCGUINNESS: That would be back to the local authority or the Health and Social Care Partnership or the Health Board.

LADY SMITH: Yes. Thank you.

MS INNES: Julie, I think you want to add to that?

MS PATERSON: Can I just add to that, that as Suzanne said, and as we've written in the report, our aim is always to have any concerns, complaints, dealt with at the local level because the service knows what's been happening best and the aim is always to resolve that, so the service may well not know about the complaint, the local area might not know about that. So we would almost facilitate that conversation to happen with the Health Board and the local authority Health and Social Care Partnership. But we would keep a wee overview of it as well to make sure that it has been resolved to the person, or the family, or the member of staff's satisfaction.

As Suzanne said, then there's levels, because if we find that that has not been addressed, or local areas have not progressed their own areas of learning, for example, if there's a significant concern, there's what's called significant adverse event reviews that can be taken -- that can take place. There's learning

reviews that can be taking place locally. We would absolutely support that and step back and allow that to happen.

We would only get involved at the high level that Suzanne spoke about where we have got concerns that that has not been taken forward and it's so significant in terms of deficiency of care, impact upon an individual, that we would then, you know, take forward a publishable report which, you know, the investigation would take over a year, usually, to look into the detail, to learn about what the local area has done or not done in order to deliver the outcomes for people.

Q. Over the next page, you say:

'It is important to note that not every instance of deficiency of care can be investigated by the Commission for a variety of reasons, including finite resources. However, [you] have a process for filtering those cases which are the most significant and thought to be the most beneficial for Scotland-wide learning.'

So, how do you identify cases where you think learning points could arise from this?

MS MCGUINNESS: We have, as part of our investigation, kind of, function, we have got an internal investigation group, which is a multi disciplinary team, and each and every referral that we'll receive from our

practitioners, it will come through in terms of any indications at all around deficiency of care, neglect, ill treatment, et cetera. We will consider -- we will never leave anything, nothing will be, like we wouldn't say we're not going to bother investigating that, just leave that. We'll -- as Julie has, kind of, alluded to, if at all possible we will work with the senior levels, the Health Board, the Health and Social Care Partnerships, in order to promote either a learning review or a SAER review, significant adverse event review, in order to ensure that local services, kind of, investigate their own and find that learning and, kind of, take that forward.

So where that's not possible, it comes to the investigation group, as I say, and then it's escalated up to our executive leadership team in terms of the investigation group will make a recommendation and our executive leadership team will then make a decision based on that recommendation to go forward.

MS PATERSON: And a focus on learning, so the whole focus is learning. So we would not undertake an investigation where the same learning looks like it will be identified in a new investigation. So it's about identifying learning that will be meaningful across Scotland. So, for example, one of our most recent ones are about

crossover of the Act, so clearly a lack of understanding of the Adults with Incapacity Act, the Mental Health Act, adult support and protection legislation, so that the person got not the service that they were entitled to, because there's a lack of understanding in relation to those three Acts and when we looked into that, we recognised that that's probably learning that would be meaningful across Scotland, not that particular area.

So when we do choose these investigation reports, we'll identify the learning is not solely in that particular local area, it's likely to be a learning need across Scotland, so that helps inform which investigation we'll take forward.

Q. I suppose, obviously, one wouldn't want learning to be lost, so there are a couple of things in what you have said. One is if the same issue has arisen again, then that might indicate that people haven't learned from what you've told them in the past. So how would you go about highlighting that, would you put that in your annual report or would you highlight that in a different way?

MS PATERSON: Various different ways. So annual report, absolutely. We do good practice guides. So where we find out that there's, you know, repeated areas where we think people should know, based on information

available, but for some reason that hasn't, you know been embedded, then we'll do good practice guides, we will do advice notes. You'll see we have got good practice guides on a range of pieces of work in relation to restraint, in relation to seclusion, in relation to covert medication.

So these are things that we pick up through a range of work that we do, that we recognise that there needs to be clarity for the services and the staff delivering those services, so yeah, we try not to lose any learning that's identified via our various routes that come into the Commission.

Q. Yes, and the other aspect, I suppose, would be if you have decided not to do a review, but it is being looked at at local level, do you get any feedback as to what's then happened as a result of your intervention and could that then feed back into practice guides, annual reports and suchlike?

MS PATERSON: It does, yes. There's a number of things. So I'm sure Suzanne was going to mention that we do training with NHS Education Scotland in relation to the Adults with Incapacity Act, because we've identified across a range of our work that we assume that people understand how to implement that Act in practice, but the various learnings suggest that's not happening. So

we were able to go to government and ask for additional resources to work with NHS Education Scotland to do a full education, you know, package for all health and social work staff. So we always do that, that different feedback, and close those feedback loops in relation to learning we identify.

And there's areas sometimes that we can't predict. We think, you know, it's known, but through the work that we do, we recognise that no, it's not known. So for example, section 47 certificates of Adults with Incapacity Act is a treatment form that we found has not been completed routinely, and although there's good guidance in relation to that, we issued a new advice note just to remind people of the guidance and we'll be doing some work this year as well, just doing some sampling to see has that guidance been embedded now or is it still an area of learning?

Q. Okay, now if we go on over the page to page 10, you look there at current activity in relation to care and treatment of children in health establishments that provide long-term care. And you note that there are no long-stay hospital facilities and as you note at the end of that paragraph:

'No hospital inpatient unit has been designed with the intention of being the primary place of residence of

a child.'

But of course, there are inpatient facilities in Scotland which can provide specialist care in respect of children. And you note that you undertake visits to the following inpatient establishments, and those are Skye House, the Melville Unit, Dudhope House and the National Child Inpatient Unit, so those are the four inpatient units specialising in care provision for children that you visit on an annual basis. Is that right?

MS PATERSON: That's correct, yes.

Q. And then you refer to what was, at the time of writing this report, the recently aired BBC Disclosure programme 'Kids on the Psychiatric Ward', which was broadcast in February of this year and focused on the experience of five young women within Skye House. And we know, from what you've told us and other evidence that we have, that the Commission, together with Healthcare Improvement Scotland, was directed, or instructed, by Scottish Ministers to visit all of the inpatient units and make recommendations, which, as you know, will be detailed in a publishable report. What's the current stage of that report, or that work?

MS PATERSON: The stage is that we have been working in partnership with Healthcare Improvement Scotland. We've undertaken visits to date, of which our visits are

unannounced, so there's only so much information I can give you at this stage, but certainly in progress. The aim would be to have all reports done individually for each unit, all be completed at the stage that the visit has completed, with the final report being completed by the end of this calendar year.

Q. Okay.

MS PATERSON: The aim thereafter will be to compile a report which reviews all four reports to see any themes arising from the four visits.

Q. Okay. So in terms of the individual reports that you aim to complete by the end of this calendar year, would these individual reports be published at that time or is that going to be later? And are you saying there's then going to be a separate report in relation to themes?

MS PATERSON: Yeah, there'll be -- sorry to interrupt, there'll be individual reports for each setting that we visited, after we visited them, and they'll be published within 12 weeks, or thereabouts, based on, you know, the governance process that will have to be gone through individually. And all four reports will be completed by the end of the calendar year. So the first report will be completed in the near future.

Q. Okay.

MS PATERSON: The final report will be a report looking at

all the recommendations across all four settings to see the themes and where there's good practice and where there's areas for improvement. So it will be looking at all four reports. But each setting will have their own individual report that will be published within -- the target is round about 12 weeks, but I wouldn't want to hold to that date, but certainly within 12 weeks of that individual visit, so there'll be four separate reports published at different times following the visits to these four settings, with the first one within the next while.

Q. Okay, so --

LADY SMITH: When you mention a governance process that will have to be gone through, what do you expect that to involve?

MS PATERSON: The governance process will be as per normal individual visit process, whereby we have accuracy checks with services, we put reports back and forth to make sure they're accurate and that we are satisfied that they meet Healthcare Improvement Scotland's governance and the Mental Welfare Commission, but their governance processes are already in place, so they're not new, so they shouldn't delay.

LADY SMITH: Thank you.

MS INNES: So for the themed report, would we be looking

into next year for that themed report?

MS PATERSON: Yeah, 2026, yes.

Q. Okay.

And then you go on to refer to another themed visit that you're carrying on at the moment, which is a joint themed visit with Care Inspectorate in relation to all of Scotland's four secure accommodation units for children. And you say:

'This work aims to review the use of restrictive practices within these units.'

And is that -- when you say it's business as usual, this isn't something that you've been directed to do by the Scottish Government, it's something that you and the Care Inspectorate have decided to do together?

MS MCGUINNESS: Yeah, this is preplanned. Last year was a preparation year and this year is delivery.

Q. Okay. Again, sort of roughly, when are we looking to for the final report in relation to that work?

MS MCGUINNESS: That should be around -- again, please don't hold me to this in terms of publication dates, or anything, but I anticipate spring 2026.

Q. Okay, thank you.

Now, if we look on to page 11, and at the top of that page, again -- well, this is in relation to monitoring, you say that another area in which you carry

out monitoring is in relation to the use of compulsory treatment for people of all ages. And you say:

'Since 2015, this has risen in respect of everybody, with the proportion of children treated under the mental health legislation rising at a similar rate.'

So this is an ongoing trend that you are seeing?

MS PATERSON: It is.

Q. But in terms of children being subject to compulsory treatment, it's not disproportionate, it's rising in proportion across the board?

MS PATERSON: Yes, it is, yeah.

LADY SMITH: And this is over last decade, this has been happening, is that right?

MS MCGUINNESS: Yes.

MS PATERSON: Yes.

LADY SMITH: Why?

MS PATERSON: Certainly the reports that we have from boards, children, adults and older people, the level of acuity has increased over the past years as well.

LADY SMITH: Is there any -- well, you say all ages, is there any particular age group amongst children that's standing out?

MS MCGUINNESS: I don't have particular age ranges, but nothing -- nothing's came across in terms of what's -- of any particular age range, my Lady. In terms of the

increase, it's really multi-factorial, we've had internal discussions about this and there's many reasons and, as Julie has alluded to, there is -- one key, kind of, factor that emerges is the level of acuity. There's no -- lots of factors.

LADY SMITH: Thank you.

MS INNES: My Lady, it's 3 o'clock.

LADY SMITH: Is that a good point to break?

MS INNES: Yes.

LADY SMITH: I promised you a break at about this stage and I don't want to break that promise. So let's have a short break and then we'll finish your evidence after that. Thank you.

MS PATERSON: Thank you.

(3.01 pm)

(A short break)

(3.11 pm)

LADY SMITH: Suzanne, Julie, are you ready for us to carry on?

MS MCGUINNESS: Yes.

MS PATERSON: Yes.

LADY SMITH: Thank you.

Ms Innes.

MS INNES: Thank you, my Lady.

If we can go back to your report, please, just on

the same page as we were on before the break, so page 11 of MWC-000000003, and below the reference to the monitoring report, you also say that you undertake visits to children under the age of 18 who are placed in an intensive psychiatric care unit, in addition to children under the age of 16 who are placed in adult wards.

So you already told us about visiting children who are placed in adult wards, but you specifically also visit children who are placed in intensive psychiatric care units, I think, as you say, if you're able to do that in the time available. Is that right?

MS PATERSON: That's correct, yes.

Q. And why do you visit these children specifically?

MS MCGUINNESS: In terms of the -- these are children that are the most vulnerable and they're being placed in the highest level, I suppose, in terms of -- which is non-forensic, but they've been placed in the highest level of a secure setting for the treatment that they need, which should be, which is adult centric, as opposed to child centric, so therefore our number one priority is always -- as we've said repeatedly today, is to hold the person at the centre, and no more so than when it's a child and a vulnerable unwell child in an adult setting, we need to go in and just make sure

that everything is as it should be for that young person.

Q. Mm-hmm.

And you then go on to say that work is underway to improve data collection in relation to this area and to correlate this data with work that's undertaken by Public Health Scotland. Can you tell us a bit more about that?

MS MCGUINNESS: Yeah, Public Health Scotland also gather data on hospital admissions, excellent data sets. However, there's a -- what's the word I'm looking for, a disconnect between the reporting periods between Public Health Scotland and the Commission's reporting period. So that kind of, when public health -- we've got to wait until they publish theirs at a certain part of the year and then we will undertake our kind of statistical analysis and kind of try and correlate the data as best we can. But it's excellent data and it very much, kind of enhances, the data that the Commission holds.

Q. Okay, and you say the aim of this work is to ensure that your data sets are as robust as they can be in order to gather data about the provision of care for children in non-specialist settings and to support service development and whether there is a need for a further

specialist inpatient service development within the country, would that be focused on children or --

MS MCGUINNESS: Yes, yes.

Q. Okay, so you're looking at that data to see if there is a need for further provision, which you could then highlight, presumably, to Scottish Government?

MS MCGUINNESS: Yes, and that's in terms of our monitoring report, that is one of the key drivers, is to effect change and provide that information across Scotland to all services.

Q. And then you go on to investigations, in terms of ongoing investigations, and you say you have no level 5 investigations relating to children planned. So you've already told us about the five levels of investigation. But you say that there are lower-level investigations in relation to the care and treatment of children.

And you give a number of 23 that happened between April 2020 and March 2023. Can you just give us a sense of, you know, what are these lower-level investigations concerning? Are there any particular themes?

MS MCGUINNESS: Each one is -- each situation is individual. Off the top of my head, restraint and restrictive practices would be a theme. And that would be in a community setting rather than a health setting.

Sorry -- off the top of my head, it will be around

children and young people, it could -- and it sounds, I don't know, in terms of you're talking about lower level, it could be as serious as a young person self-harming, or worse, in terms of the concerns that are raised to us and we will undertake an investigation. But not at the level 5, probably looking at level 3 type thing, in between, where we will ensure that we've got an outcome and there's something else kind of going on locally in order to learn from any outcomes that were unsatisfactory.

Q. Okay.

Then the next heading is in relation to advice and guidance. And you note that you've got an advice line and you note the number of calls that you get to this advice line, and you've given us a statistic that between April 2020 and March 2023, you received and gave advice in relation to the care and treatment of 409 children. And in terms of the people calling the advice line, is it a variety of people or is it parents and carers, or professionals?

MS PATERSON: It's a combination. So our advice line, it's anonymous, people can call us anonymously. There's a line specifically for people who do not work in mental health services and a separate telephone number for people who do work in mental health services.

So in terms of the data that we have, it's almost 50 per cent/50 per cent. So 50 per cent of the people who call us are people who are using services or carers/relatives, and the other 50 per cent are people who work in mental health services.

Q. Okay. And is this then a route from which you can, sort of, build the intelligence that you've been talking about that then might lead to further investigation?

MS PATERSON: Absolutely. Investigations or themed visits or a local visit, so if we have a number of people telephoning us about a particular unit, that might add to the intelligence about decisions, about visiting, it might add to investigations, it might add to additional work, I think I mentioned earlier, about authority to discharge work that we did, that was a direct result of the number of calls we had from, you know, relatives, families, individuals, and doctors, nurses and social workers about unlawful moves from hospitals to care homes. So that all came from the advice line.

Q. And then you talk about the response to the incorporation of UNCRC and your work in relation to that is to audit and, I think, update your guidance and advice notes, particularly in relation to children?

MS MCGUINNESS: Yes.

MS PATERSON: Yes.

Q. Right, and that's an ongoing thread of work?
MS MCGUINNESS: Yes.
MS PATERSON: Yes.
Q. And when you say at the top of page 12 that you intend to use feedback that you are getting from the consultation exercise, you:
'... intend to use this feedback to inform our work to widen our guidance and advice for children.'
Is that advice and guidance that can be directly accessed by children and young people?
MS MCGUINNESS: Yes, it includes direct access.
Q. Okay. And then you mention the final area of your role, which is influence and challenge. And you note some of the broader aspects of work that you have been engaged in with other partners, including, for example, NHS Education Scotland, as you've already mentioned, in different areas of work. So for example incorporation of UNCRC is another area of work that you've collaborated with NHS Education Scotland as well, I think?
MS MCGUINNESS: Yeah.
Q. Then you go on to talk about the MWC's role in providing guidance. And you say in relation to the reports from visits to local hospital wards -- which you've already told us are published -- you say that that began in

2010. So prior to that date were these reports not published?

MS PATERSON: I think that's my understanding. We weren't at the Commission at that point, but the reports were certainly provided to the services. But I'm not convinced that they were published at that point. But we can certainly confirm that fact for you.

Q. Okay.

MS PATERSON: Something that we've also introduced over and above publishing, we spoke earlier about themed visits and recommendations, and I didn't explain to you the fact that when recommendations are made and we expect a response from services for themed visits and investigations, we then publish closure reports which say what the responses have been and, you know, the assurance that's been given and that was introduced in 2021.

Q. Okay. And then you go on to refer to various ways in which you provide guidance and advice: the advice line that you've referred to, publishing guidance on your website and also guidance and advice forming part of your recommendations.

If we can go on over the page to page 13, you talk there about how you hear the voice of children with disabilities or additional support needs, and you refer

to visits to the hospital inpatient units who are specifically for children. And you say that:

'Over time inpatient services have changed radically and a regional model of inpatient provision is now established across Scotland for 12 to 18-year olds and a national model for children under the age of 12 years ...'

So when you referred to the various units, I think Skye House, Melville and Dudhope, those are for 12 to 18-year olds, is that right?

MS MCGUINNESS: Yeah.

Q. And the National Inpatient Unit is for younger children?

MS MCGUINNESS: Yes, it is.

Q. Okay, so potentially, I suppose, children could be in that unit quite far away from their home?

MS MCGUINNESS: They could be, yes.

Q. And then you go on to say that a key part of your visiting activity involves speaking directly to the child themselves. You try to maximise engagement with children willing to speak to you by preparatory work before any announced visits.

So that's what you talked about earlier, if there's an announced visit, you'll get the wards to help you in advance?

MS PATERSON: That's correct, yes.

Q. And you say that you particularly ask to speak to children who want to speak to you?

MS PATERSON: Mm-hmm.

Q. Whose first language is not English, children who have communication difficulties. Why do you specifically ask to speak to children who have communication difficulties or whose first language is not English?

MS MCGUINNESS: Because we know from the work that we do that people whose first language is not English, or communication -- or young people with communication difficulties, may be less heard voices out there, more widely. So we will strive to ensure as far as we can that those voices are heard.

Q. And then you also -- the final point there, is also people who are care experienced?

MS MCGUINNESS: Yes.

Q. So, is it a similar reasoning, that you particularly want to hear the voice of care experienced --

MS MCGUINNESS: Yes, again, the Commission, as a -- we're deemed to be a corporate parent. But equally we've got an interest anyway in all children, but particularly care experienced. The greater vulnerability there.

Q. Okay. And you note just below this, a disadvantage of when you visit on an unannounced basis is that the preparatory work can't be undertaken, and therefore you

have less of an opportunity, perhaps, to meet with children and families, because you just turn up on the ward, I suppose?

MS PATERSON: Absolutely. We turn up on the day and it is one day, and it's a snapshot in time, so the opportunities for families who may be at work, or other plans, you know, we're less likely to meet with them on that day.

Q. And then at the bottom of the page, you talk about your engagement and participation team who may also form part of the visit team. And you say:

'We are continuing to develop work in this area and are aiming to identify certain visits in our programme in which our engagement officers will visit the ward and spend time with patients and their families separate to the Commission practitioner visit to ascertain people's views.'

Can you explain that a bit further?

MS PATERSON: Practitioners who visit on the wards are primarily doctors, social workers and nurses, and we appreciate people don't necessarily want to speak to a doctor, nurse or social worker. So we really want to extend our visiting programme with our people who have got experience and who can understand some of the experiences that the people on the ward are currently

experiencing.

So engagement participation officers, for example, include people who are experienced as carers, you know, relatives who have, you know, children who have experienced CAMHS services, inpatient services, so to include them as part of our visiting group, we hope that they might be able to engage maybe more or people may be more willing to engage with people who have shared the same experience. So the more that we can use our staff, the resources we've got, to engage with people and to have people trust and speak to us, the better our work can be.

Q. And are these people employed by the MWC --

MS PATERSON: These people -- yeah.

Q. -- or are volunteers? They're employed?

MS PATERSON: All our visitors are employed by the Mental Welfare Commission, whether that's practitioners or engagement participation team, they're all independent as part of the Mental Welfare Commission. And if anybody has worked in a local area, then we would never visit that area for at least two years to ensure that independence from that unit or that geographical area.

Q. And then you go on to talk about visit posters with photographs and details of Commission visitors to try to support engagement. And then you say although there is

no specific inpatient facility for children with intellectual disability, many of the children that you do see when you visit have autism and other recognised additional support needs.

Do the visitors have specialist skills in communication with children who might have communication differences?

MS PATERSON: A range of our practitioners have a range of experience across -- we have a specialist consultant psychiatrist on learning disability, for example. We have specialist psychiatrists with CAMHS expertise prior to coming to the Commission. So there's a range of expertise that we learn from each other, and -- but we absolutely want to learn from other partners, for example, speech and language therapy, who may well be on the ward can help us to communicate as well. We also have as part of our engagement participation team somebody who does have autism, so helps us, either on visits, or helps us in terms of how we fulfil our roles and responsibilities too. So engagement participation we have -- I mentioned carers, we also have somebody with a mental illness who works with us, employed by us to support us in our work, and somebody with autism too.

LADY SMITH: What about children whose first language is, for example, British Sign Language, what do you do about

that?
MS PATERSON: We -- sorry.
MS MCGUINNESS: Yes, we do have access to various external organisations that will support us in order to ensure that we've got the communication aids or supports that's required.
LADY SMITH: So that would only work then in the case of an announced visit?
MS MCGUINNESS: Announced, yes, it would.
LADY SMITH: Does that inevitably mean that such a child is excluded from communicating with you during an unannounced visit?
MS MCGUINNESS: I think, on the face of it, potentially it could be seen like that, but the fact that it's unannounced, particularly when we're talking in the context of children's visits, is telling you something, really. Because we do regular visits to children and young people's wards in any event.
LADY SMITH: Of course.
MS MCGUINNESS: So the fact it's unannounced, it's an intelligence-led kind of visit.
LADY SMITH: Okay. So if that was a requirement, you'd hope your intelligence had had pre-informed you about that.
MS MCGUINNESS: Exactly.
LADY SMITH: And the same if it's a foreign language, I take

it?
MS MCGUINNESS: Yes.
LADY SMITH: Thank you.
MS PATERSON: Can I just add that there's nothing to preclude us from going back. So if we go on an unannounced visit and we find that we don't have the skills and abilities to communicate or in a way that we would like to, there's no reason why we would not go back specifically to meet those specific children and young people.
LADY SMITH: Of course, thank you.
MS INNES: And to what extent, if at all, would you rely on staff members to assist you with communication?
MS PATERSON: Potentially, if that child or young person or adult, that's their choice, if they're quite happy for that. We would also expect that if, you know, we have a child or young person on a ward whose first language is not English, that the ward would have made arrangements to make sure communication with them is clear.

So we certainly have got experience where we know, for example, an interpreter has been used, and we've used that interpreter that the ward has been using to support that child and young person. So we would expect already the communication needs would have been

addressed and we would be able to, you know, use these if they're already in place.

Q. Okay.

Now going on over the page to page 15, you talk about your responsibility for safeguarding and child protection. And as you note:

'Adult and child protection is everyone's business.'

And everyone has a role to play in this.

You say that as a consequence of your work -- in the next paragraph, as a consequence of your work, you've got the duty to highlight any child protection or safeguarding concerns to the relevant authorities when they come to your attention, and Commission practitioners, staff, or -- presumably have child protection training, do they?

MS PATERSON: That's correct, yes.

Q. And is there a particular policy or procedure in relation to child protection, or safeguarding concerns, that would tell somebody how those concerns would be escalated should they be raised with a member of Commission staff?

MS MCGUINNESS: In terms of?

Q. Well, who should they tell if, on a visit, a child makes a disclosure of a child protection concern?

MS MCGUINNESS: So our staff?

Q. Yes.
MS MCGUINNESS: Yeah, so our staff would raise that on the day immediately in terms of child protection, and it would be followed up to ensure that it had been followed through.
Q. Okay. And do you have a particular procedure in place?
MS MCGUINNESS: We've got a visit for that, kind of -- we've got a visit standard operating procedure.
Q. I see.
MS PATERSON: All our staff are registered professionals, so they have a duty in terms of their own registration to make these referrals to the local authority and to know how to do that. And to follow them through. And, you know, to -- if there are concerns that haven't been addressed, then we've spoken about investigations previously. Whilst we don't deal with concerns and complaints, we do keep an overview, if they haven't been addressed the way that we would anticipate, then we would become involved.
Q. Okay.
Now, if we move on to page 16, where you're asked to evaluate the effectiveness of the Commission in preventing or detecting the abuse of children accommodated in relevant establishments. And you say that your effectiveness in this area relies heavily on

the provision of information to the Commission about any particular concerns.

So it would depend on, things like you said, things coming up during visits, issues being raised on your advice line or a particular concern being highlighted by another organisation, for example, and then you taking action thereafter.

Is that --

MS MCGUINNESS: That's correct.

Q. -- the sort of process?

You -- as you've said before, you're not a complaints organisation, nor are you a whistleblowing organisation. But the very nature of your work means that from time to time you may obtain information and on rare occasions, you may be contacted by staff who wish to raise service concerns. And you say the way in which you deal with that is remind them of their duties and refer them to the relevant whistleblowing process?

MS MCGUINNESS: We do.

Q. And then you say you would also use the information given by way of informing your work?

MS MCGUINNESS: Absolutely we would, yeah.

Q. Okay.

And then I think you refer to notifications. Yes, sorry, that was at the top of the page. You refer to

a notification process. And you've provided a link to your website. And I think one of the things that has to be -- or ought to be, notified to you is incidents where it appears that there has been a deficiency in care or treatment and as a result somebody has suffered serious injury or adverse physical effects, which could be a result of restraint or where somebody has been injured by another person. So --

MS MCGUINNESS: Yes.

Q. -- who is it that would be required to make such notifications to you?

MS PATERSON: A number of people, to be honest. People should know, and we strive to make sure people know the role and remit of the Mental Welfare Commission in relation to people with mental health conditions. So we refer to the Mr E investigation in our report, and it was the Mental Health Tribunal for Scotland, for example, that made that referral to us, because they were concerned in relation to the care and treatment of Mr E prior to the tribunal hearing, you know, that particular case. So that was one referral.

We have expert referrals from professionals, because, as we've said, in terms of their codes of practice they have a duty to highlight deficiencies in care. We will hear from relatives, we will hear from

a number of people in relation to their concerns, so that notification ensures that we have all of that information.

Q. And what do you then do with the information that you obtain as a result of a notification?

MS MCGUINNESS: We've got multiple notifications, and that would depend on it, but if we're talking, on particular, concerns we will make further enquiries immediately. You know, it will be a priority if you're talking about significant harm, or where there's imminent risk of or actual harm, then yes, our local area practitioner, each practitioner within our organisation is dedicated to a specific geographical area, the Health and Social Care Partnership and Health Board, so it will be passed to them to make enquiries. And it would either, if it came through to executive level, if you're on duty exec you will hear it, or it will get escalated up through the Commission when it's something of significance.

Q. And do you audit these notifications in order to see any developing themes or concerns?

MS MCGUINNESS: In terms of the notifications that come through, again, you'll see a number of them. In terms of audit, because they're all linked also into our monitoring process, so you're kind of looking at that. So each one is kind of -- we don't -- we can't look

at -- there's over 40,000, 46,000 forms, or something, come through our doors every year. But for the notification ones, we will, for example, or there's a -- it's called an ND1, a death notification, each one of them will be looked at. We've talked about ADM2, we talked about the children being admitted, each one of them will be looked at by a practitioner. But other notifications, they will come through, and it will depend on the nature of the notification, is a simpler way of putting it.

Q. It was really, for example, if you were getting, you know, a large number of notifications from one ward, for example?

MS MCGUINNESS: Oh yeah.

Q. Would you notice that being of --

MS MCGUINNESS: Oh yeah, we would absolutely notice that again, because of the -- kind of, the make-up of the practitioner groups, that intelligence would go through and that would be escalated quite quickly.

Q. Okay.

Then at the very bottom of page 16, you say from the recommendations that you make through your visits and investigation, you have a robust follow-up process which follows the requirement of action plans from the service which you monitor, review and either advise that you're

satisfied or request further action.

And then you go on to refer to the closure reports that you've already mentioned in your evidence, that that is the end of that process, once you're satisfied that the follow-up has been carried through?

MS PATERSON: That's correct, yep.

Q. Okay.

And then over the page, at the top of page 17, you say that you also meet annually with senior leaders from all health boards and Health and Social Care Partnerships, through which you discuss and progress updates in relation to significant matters brought to your attention. So any key issues or themes would be discussed with health boards and Health and Social Care Partnerships at that annual meeting?

MS MCGUINNESS: Yes.

MS PATERSON: That's correct, yes.

Q. And it would be an opportunity for them to raise anything with you as well, I assume?

MS MCGUINNESS: Yes.

MS PATERSON: Yes.

MS INNES: Okay.

I don't have any more questions for you, thank you.

MS PATERSON: Thank you.

LADY SMITH: And nor do I. I just want to thank you again

for coming here this afternoon. It's been so helpful to hear from you in person about the work of the MWC, the width of its work and the depth of its work, which I'm sure you feel in the time we've given you, you've really only been able to skate over the surface of, but it's clear just the amount that you do, and I thank you for that too.

You're also the last two witnesses in this phase of our work here, so thank you for being that and coping so well.

Do feel free to go. Safe journey home.

MS MCGUINNESS: Thanks, my Lady, thank you.

MS PATERSON: Thank you.

(The witnesses withdrew)

LADY SMITH: They may be the last witnesses, but that's not the last hearing day for this section.

Now, when I last checked, we were still on schedule for next Friday, is that correct, Ms Innes?

MS INNES: Yes, my Lady. Closing submissions will be on 17 October, commencing at 9.30 am.

LADY SMITH: Yes, thank you very much. Well, I'll rise 'til then.

Thank you.

(3.41 pm)

(The Inquiry adjourned until 9.30 am
on Friday, 17 October 2025)

I N D E X