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Independent Inquiry into Abuse at Kerelaw Residential School and Secure Unit

Jointly commissioned by the Scottish
Government and Glasgow City Council

An independent inquiry led by **EDDIE FRIZZELL**

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KERELAW RESIDENTIAL SCHOOL AND SECURE UNIT – REPORT OF THE INDEPENDENT INQUIRY

i FOREWORD

We ask a lot of those entrusted with the care of our children and young people. We expect them to keep their charges safe, to guide them, to set an example and to prepare them for adulthood and independence.

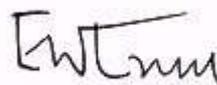
For those working in residential child care they must provide a home for vulnerable children, substitute for relationships which would be taken for granted in a stable home environment, and at the same time maintain professional boundaries. They must be able to encourage, comfort and at times control.

Most of the time they perform a difficult task, out of the public eye and largely out of the public mind until problems erupt, or a tragedy occurs which brings their work into the spotlight. In such circumstances all residential child care workers are caught up in the consequences, whether involved or not in the events in question.

In carrying out this Inquiry, the team gained an insight into a world which few people care to think about, far less enter. We saw what can happen when staff lack direction, when leadership is inadequate, when appropriate values are not upheld, and when poor attitudes are not challenged. We saw the impact of relative neglect of an institution by senior managers 30 miles away preoccupied with reorganisation, budgets, high-level policies and internal disputes.

The impact on those who were abused at Kerelaw was devastating. A number of ex-residents will require support for some time to come; for others it is an experience to put behind them as best they can. Some, who were not abused, have had what was a positive experience for them besmirched. For many former staff the consequences have also been devastating. We interviewed a number of broken people – ex-workers as well as ex-residents - and we heard from others working with young people who felt a stigma from Kerelaw had affected them and all residential child care workers.

It would be a great pity if that were so. While those who were involved in abuse at Kerelaw deserve to be condemned and held to account, it should be recognised that there were also good practitioners at Kerelaw, and that many young people valued the care they provided. Kerelaw has closed, but there are still many young people who need residential care. If their needs are to be met, our social services require a trained and dedicated workforce which is valued by the public and by their employers. We should not let the Kerelaw experience make that more difficult to achieve.



E W FRIZZELL CB

April 2009

ii CONTENTS

	Page
i Foreword	1
ii Contents	2

Chapters

1 Executive Summary	3
2 Background	13
3 Introduction	14
4 Kerelaw Residential School and Secure Unit	19
5 Looked after children legislation and regulation	26
6 Policy trends and initiatives	30
7 Range of allegations of abuse	34
8 The nature of abuse	39
9 Organisational culture	50
10 Capacity for improvement	64
11 Inspection	77
12 The child at the centre	84
13 Glasgow City Council's stewardship of Kerelaw	93
14 The closure of Kerelaw	103
15 The Glasgow City Council investigation and discipline of Kerelaw staff	107
16 Disqualification from working with children	122
17 Lessons learned by Glasgow City Council	127
18 Analysis and conclusions	133
19 Recommendations	143

Annexes

Annex A Terms of reference	148
Annex B "Rules of engagement"	150
Annex C Sources of Evidence	151
Annex D Discipline and grievance procedures - statutory requirements and good practice	152
Annex E List of abbreviations	154

1. EXECUTIVE SUMMARY

The Inquiry

1.1 The Inquiry was commissioned by the Scottish Government and Glasgow City Council in November 2007. Its purpose was to secure comprehensive insight into the circumstances that led to abuse at Kerelaw Residential School and Secure Unit over a period of years, to examine Glasgow City Council's stewardship of the school since 1996 and to consider the Council's investigation of what occurred and the arrangements following closure of the school between 2004 and 2006. The Inquiry was asked to make recommendations to ensure similar circumstances could not arise again and to offer any other insights relevant to the safe care of young people in residential settings.

Our methods

1.2 A small Inquiry team comprising the chairman, 3 further investigators and an office manager examined a large volume of paper and electronic records held by Glasgow City Council. We contacted a wide range of organisations and individuals and conducted 166 interviews. The notes of these interviews formed a central core of evidence to the Inquiry. We received and examined written material and testimony that was of relevance to the residential care of young people or specifically to the operation or staffing of Kerelaw or to residence in the school. We drew on expert advice from a small group of external advisers. The Inquiry took place in private to encourage more open communication on some very sensitive and personal issues, and we committed to anonymise the information provided by interviewees when preparing our report.

Kerelaw Residential School and Secure Unit

1.3 Kerelaw opened in Stevenson, Ayrshire in 1970, initially as a residential school for 72 boys, and later became co-educational. A mixed sex Secure Unit was added in 1983 and extended in 1988 to cater for a further 24 young people. Most were placed under a supervision requirement, with smaller numbers on remand or sentence. All had significant behavioural, emotional and/or educational needs. Education was provided up to statutory school leaving age, and young people had access to a range of specialist support including psychology, psychiatry and addiction counselling. As a result of local government reorganisation, Glasgow City Council took over the running of Kerelaw from Strathclyde Regional Council in 1996. At that point Kerelaw comprised 4 Open School units housing a maximum of 24 boys and 24 girls and the Secure Unit containing 16 boys and 8 girls. Compared with other residential accommodation for young people in Scotland, Kerelaw was the largest local authority-run establishment and catered for some of the country's most challenging and vulnerable young people.

Legislation and regulation

1.4 During Kerelaw's existence there were significant developments in the regulation of care for looked after children and changes in public and professional attitudes towards large residential institutions. During the period covered by the Inquiry there were three legislative developments of particular note - the Children (Scotland) Act 1995, the Regulation of Care (Scotland) Act 2001 and the Protection of Children (Scotland) Act 2003.

1.5 The Children (Scotland) Act 1995 brought conformity with the UN Convention on the Rights of the Child and served to place the child at the centre of official decision-making. It promoted inter-agency co-operation and the development of effective individual care planning for young people. Regulations and guidance outlined the role of external management in relation to looked after children. The Regulation of Care (Scotland) Act 2001 aimed to provide better protection for those in care and created The Scottish Commission for the Regulation of Care (The Care Commission) as an independent body charged with the regulation and inspection of care services. The Act also established the Scottish Social Services Council (SSSC) as the registration body for social workers and others working in social care, with responsibility for setting standards for qualifications and behaviour of care workers. The Protection of Children (Scotland) Act 2003 provides for the disqualification of unsuitable people from working with children.

Policy trends

1.6 These regulatory changes underpinned policy developments in residential care that would impact on the residents and staff of Kerelaw. A growing ambivalence towards the use of residential care for young people from the early 1990s led to a move towards favouring foster care and a view that resorting to a residential placement was a failure. As fewer young people were placed in residential care, those who were so placed had more complex needs. Such young people were more likely to have experienced one or more failures of care in a different setting. We were told that an increasing number of those placed at Kerelaw had problems with drug or alcohol misuse and, as the complexity of the problems increased, more and more placements took place on an emergency basis. Despite the pressure for change represented by regulatory and policy developments, the pace of change at Kerelaw was slow.

Abuse and physical restraint

1.7 Glasgow City Council reported in 2007 that there were between 350 and 400 allegations from 159 people complaining of emotional, physical or sexual abuse. Two staff were convicted of physical and sexual abuse, and one of physical abuse, as a result of police investigations. A further case of alleged sexual abuse was not proven. It was not the role of the Inquiry to examine individual allegations of abuse, nor to re-run investigations into whether abuse occurred at Kerelaw. However, to fulfil our remit, it was important to understand the range of allegations made and the nature and scale of abuse.

1.8 Some young people testified to Council investigators and to the Inquiry that they had a positive experience at Kerelaw and had never been subject to abuse themselves. Similarly, some former staff said they had never witnessed abuse of young people. Other young people were clear that they had been poorly restrained and hurt as a result, and some said that they had been assaulted without any pretence of a restraint. Some staff admitted to the Inquiry that they had undertaken restraints that were poorly executed and probably caused pain, while others acknowledged that they had taken action in a restraint that they now recognised as inappropriate. Nobody admitted to the Inquiry that they had intentionally assaulted a young person in their care, although some staff and young people did describe having seen one or more members of staff assaulting someone.

1.9 This pattern of restraint and assault must be considered in a context of developing policy in relation to crisis intervention. Until 1995, there was no single, accepted method for managing conflict or violent behaviour, although some staff at Kerelaw said that they had

been trained in the 1980s and early 1990s in pain compliance techniques of the kind used in prisons and secure psychiatric hospitals. In 1995, Strathclyde Regional Council adopted the Therapeutic Crisis Intervention (TCI) model for preventing and managing challenging behaviour in young people. TCI includes restraint methods, but its primary purpose is to de-escalate critical situations and reduce the need for restraint. Nevertheless, a significant number of staff and young people saw TCI solely as a method of restraint and some used physical intervention as a first rather than last resort in dealing with difficult behaviours. Such physical intervention was often inappropriate and poorly executed. Some staff took the view that TCI was not appropriate for the very challenging young people at Kerelaw and that it was not physically possible to restrain a young person in the way described in the training manual.

1.10 We heard about “horseplay” that still took place after policy guidance advised that it was inappropriate, and we heard that language was used that belittled and undermined the already fragile self-esteem of many of the young people at Kerelaw. Some staff developed negative attitudes towards young people which were played out in emotionally abusive terms. The language of failure and “dumping”, ridicule about family backgrounds and teasing and bullying seem all to have played a part in the emotional abuse of residents. Appropriate boundaries were not always maintained between young people and their care workers.

1.11 As in other residential child care establishments, there were allegations of abuse and complaints over the years. Some complaints concerned day-to-day issues, such as food or clothing, privileges or entertainment. Many, however, complained of emotional abuse including bullying and of pain inflicted during restraint. Some alleged assault. Some complaints and allegations were investigated and we found some evidence of effective handling and follow-up which reflected concerns about the way Kerelaw was operating and the behaviour of certain staff and managers. However, the system was inconsistent, and we were told by residents and staff that not all complaints were acted upon. We saw evidence that even concerns arising from complaints by placing authorities other than Glasgow were not properly followed through to a conclusion.

1.12 The Inquiry concluded that over a period of years, although a range of allegations, complaints and concerns emerged, and were investigated, there was no systematic overview taken of what lay behind them and such findings as emerged produced no lasting effect. It was not until the Summer of 2004 that this pattern was broken when Glasgow City Council established a joint Social Work/Education investigation team to look into current and historic allegations of abuse at Kerelaw.

Organisational culture

1.13 The regulatory and policy developments of the 1990s required staff in residential care settings to gain new knowledge and to adopt new practices, and there is some evidence from recruitments made to the senior management team of Kerelaw that external managers recognised the need for Kerelaw to adapt and adjust to the new environment. Unfortunately, modernisation initiatives met resistance from within in the form of a culture that promoted the status quo. As a result Kerelaw did not move forward as it needed to do.

1.14 A staff group that is sometimes ambivalent towards the young people it cares for, or that feels poorly equipped, unsupported by management and undervalued by its employer and the wider public is likely to feel isolated and vulnerable, and may be resentful and angry. This

can lead to the development of an inward-looking, defensive ethos which puts solidarity with one's colleagues above other priorities. Solidarity with one another in difficult circumstances may be reinforced where large numbers of staff are recruited from, and live in, the local community, and where there is shift work and shift-based socialisation outside working hours. These negative cultural influences were all present at Kerelaw.

1.15 However, such solidarity did not result in a united staff with a common sense of purpose. There were animosities, allegiances, factions and cliques, seemingly based on some very strong feelings, both personal and professional. The culture was described as "macho", not in relation to the gender balance but to attitudes and behaviours exhibited by certain staff. Splits in the staff group were not confined to care workers, but extended to the senior management team. A number of interviewees told us they felt the divides were generated by the factional behaviour of senior managers. One such divide, between the Secure Unit and Open School, was deepened by management changes instigated in 1999. In the mid-1990s unit managers were given increased autonomy in an attempt to promote quality improvement, but which instead generated unhealthy competition between units and a degree of mistrust and resentment. There were also divisions between the night staff and others and, more generally, divisive behaviours by some managers and workers.

1.16 For much of its existence, the recruitment practices operated by Kerelaw did not comply with the policies of Strathclyde Region or subsequently Glasgow City Council, but it was not until 2001 that the school was brought into line and Human Resources (HR) staff from HQ took an active role in overseeing the recruitment process. Prior to that, practices often resulted in temporary and casual staff, some of whom were related to or known to recruiters, drifting into permanent employment. The relationships they had formed were either sustained or dissolved while they worked together at Kerelaw. Former residents told the Inquiry that the details of staff relationships were common knowledge throughout the school, and it was difficult to raise concerns as people could not be sure whom to trust. We were told by former staff and managers that Kerelaw struggled to attract and retain staff over the years and that vacancies led to significant reliance on overtime and casual staffing, which had implications for the quality of care.

1.17 Despite the considerable pressure from this negative culture, there were good, child-centred staff who succeeded in doing their best for young people in difficult and challenging circumstances. Those individuals were not, however, the predominant cultural influences on Kerelaw.

Capacity for improvement

1.18 Systems and tools existed that could have been used to change the culture at Kerelaw but it was not seriously addressed. Like many other public bodies, Glasgow City Council did not have an effective performance management system during the 1990s. For staff in social care, including senior and external managers of services, a system of professional supervision existed and should have been used to address many of the issues of practice that arose at Kerelaw. Staff working at Kerelaw would have needed the emotional, practical and professional support provided by supervision, but they did not receive it on a regular basis. Some had infrequent supervision, and others told the Inquiry they had none at all.

1.19 Other factors militated against sustained forward progress for Kerelaw. There was significant senior management "churn" at Kerelaw and in Glasgow's Social Work

Department from 1996 onwards. There were few senior managers who sought to bring about significant change to the way Kerelaw operated, and those who tried met considerable resistance and a lack of support from colleagues, with the result that new initiatives resulted in little lasting change.

1.20 Staff training and development should have been a key tool in modernising Kerelaw and ensuring that practice kept pace with the changing regulatory and policy framework. There seems to have been little training and development offered to staff at Kerelaw until the early to mid-1990s, when efforts were made to ensure staff received at least basic introductory training in child care. Some were encouraged to pursue professional qualifications. Staff were also trained in TCI, but follow-up refresher training was not systematically provided. While many staff welcomed training and reflected in their evidence to the Inquiry on the benefits this had had for their approach to work, others were said to be dismissive and resistant. Training did not deliver the cultural benefits that would have been expected as it was neither integrated with supervision nor positioned within a clear and unified vision of the kind of organisation Kerelaw should have aspired to be.

Inspection

1.21 A number of different organisations were responsible for the inspection of Kerelaw over the period from 1996 to closure, including North Ayrshire Council, HM Inspectorate of Education (HMIE), the Social Work Services Inspectorate (SWSI) and latterly the Care Commission. The Scottish Executive Health Department (SEHD) was also involved. North Ayrshire Council carried out annual inspections and covered both the Open School and the Secure Unit until 2002. The Secure Unit was also subject to regular inspection by SWSI and HMIE for approval purposes on a 3-year cycle. HMIE inspected the Open School in 2001 and then jointly with the Care Commission in 2003 and 2004.

1.22 Numerous concerns were raised in inspection reports over the years, but there was little evidence of sustained action by Kerelaw or Glasgow City Council to address these. Staffing levels, supervision, training, the fabric of the buildings, privacy and dignity of young people, and the complaints procedure were all subject to criticism. However, while separate agencies conducted separate inspections, there was a distinct lack of overview, a factor in the inadequate follow-up by management. The Care Commission have recognised concerns about the provision of care in residential schools and have made recommendations to improve those services and have taken action to improve the quality of inspection practices.

The child at the centre

1.23 The Inquiry did not gain a sense that the rights, needs and welfare of children were central to the operation of Kerelaw or the actions of all staff who worked there. While some ex-staff told us they encouraged advocacy services, social workers and others to visit young people in Kerelaw, many of the advocacy workers we spoke to expressed concerns about being excluded, obstructed or treated dismissively by some unit staff.

1.24 An effective complaints system is key to safeguarding young people in residential care, but we heard mixed accounts of the system at Kerelaw both from former residents and staff. Problems with the complaints system were regularly raised by inspectors. By some accounts the system worked well and was effective. Others said that complaining was discouraged, that the system worked inconsistently, or that complaints were not followed

through so for some there was no point in making them. We were told by some staff that young people could only complain by accessing a form through the unit manager.

1.25 In 2001 Glasgow City Council implemented new complaints procedures that standardised processes for complaints and child protection issues and aimed to distinguish between formal and informal complaints. The new procedures also set down reporting and monitoring requirements. However, Kerelaw was excluded from these new arrangements and central monitoring arrangements did not apply.

1.26 Although the admission of young people to Kerelaw should have been on the basis of formal assessment and planning, the Inquiry learned that many admissions took place on an emergency basis. As a local authority resource, Kerelaw was not in a position to be as selective as other establishments and as a result came to be seen by some as a safety valve for a dysfunctional system. Expectations of the quality of care and positive outcomes for young people resident there were not high. Problems inherent in the school were compounded by poor throughcare and aftercare planning and provision.

1.27 The Inquiry also found a mixed picture of the arrangements for needs assessment and care planning for young people placed in Kerelaw. The large number of emergency admissions, shortages of field social workers and significant caseloads did not facilitate effective care planning. Evidence suggested some effective planning by field social workers, but poor record keeping led the Inquiry to have concerns about the adequacy of care planning and delivery. The importance of care planning was emphasised to staff at Kerelaw from the mid-1990s, and some former employees told us that they welcomed this, although the Inquiry found little evidence to substantiate it.

1.28 Absconding appears to have been routine for many young people at Kerelaw and staff responses varied. Some saw absconding as adding to the complexity and pressure of their jobs, while others recognised the importance of trying to prevent it and of dealing sensitively with young people when they returned, often under the influence of alcohol or drugs. There was no clear evidence of any consideration of the reasons why young people were absconding.

1.29 A number of ex-residents related poor experiences of education at Kerelaw, although some achieved qualifications. Ex-residents described classes being disrupted, while teachers spoke of the difficulties of educating a shifting population of young people, many of whom had missed significant periods of schooling.

Glasgow City Council's stewardship of Kerelaw

1.30 The timing of local government reorganisation in 1996 was not helpful. Senior Council managers found themselves having to respond to major changes in legislation and regulation while under serious financial pressures. In the immediate aftermath of reorganisation, much senior management time in Glasgow was devoted to dealing with the consequences of a financial settlement that created major difficulties for social work services provision. Kerelaw was both a generator of revenue and a drain on resources, and financial issues diverted senior management time in the Council from proper consideration of the quality of provision or the future direction for the establishment.

1.31 Prior to local government reorganisation, the external management of Kerelaw was provided by Strathclyde Regional Council and the Inquiry was told that arrangements worked reasonably well, although a relatively “hands-off” approach to how Kerelaw was run seems to have been the norm. Once responsibility transferred to Glasgow City Council, external management was unsatisfactory. Responsibilities were inappropriately delegated, and burdens on managers meant that they made few visits to Kerelaw. This lack of visibility and oversight was compounded in later years by poor relationships between internal and external managers. Poor relationships within the senior management team in the Council’s Social Work Department militated against effective action being taken. The Inquiry concluded that Glasgow City Council did not give Kerelaw the attention it needed or deserved.

Closure of Kerelaw

1.32 The Open School closed at the end of December 2004 and the Secure Unit in March 2006. Some former staff and managers interviewed by the Inquiry suggested that Glasgow City Council was looking for an excuse to close Kerelaw and the uncovering of allegations by the joint investigation team, and subsequent Care Commission/HMIE inspection, provided it. This suggestion does not fit either with the Council’s dependency on Kerelaw for accommodation, or with the evidence given to the Inquiry. There is evidence that in the course of the Summer of 2004 senior management in the Council began to doubt whether Kerelaw should continue, but this was not, so far as the Inquiry could establish, why the investigation was set up or why inspectors were called back in. A formal proposal to close the school was made to committee in October 2004 and agreed by elected members. The decision gave rise to considerable grief on the part of those young people who were still resident at Kerelaw, but the evidence is that planning for the future of those remaining residents was appropriately and professionally handled.

Investigations and disciplinary process

1.33 Glasgow City Council set up its joint Social Work/Education investigation of Kerelaw following an investigation into staff complaints of bullying and harassment by a unit manager. During that investigation a number of other staff and young people came forward with allegations of poor treatment and abuse. Separately, historic allegations precipitated a concurrent police investigation into Kerelaw. As this and the internal investigations continued, and the net widened, more and more allegations were made. The two investigations remained separate, although there was regular communication and information flow.

1.34 The Council’s investigations continued for 3 years and resulted in 29 disciplinary hearings, followed by internal appeals against dismissal and in some cases Employment Appeals Tribunals which have now spanned a period of more than 4 years. As a result of the investigations and disciplinary processes, 14 staff were dismissed. Two of the dismissals were deemed unfair by Employment Appeals Tribunals, and the Council withdrew its defence in the case of another two.

1.35 Many ex-Kerelaw staff criticised the handling of the investigation, feeling that the approach was aggressive and the process poorly handled and over-long. Staff felt they were not adequately informed about the allegations against them and that they therefore found it difficult to respond adequately. On the other hand, some were unwilling to cooperate and the joint investigation team faced the challenge of finding a way through the networks of cliques

and relationships which they concluded had obstructed a number of fact-findings over the years. The investigation team had a complex and difficult task, but the Inquiry was nevertheless surprised by the lack of attention to detail in some fact-finding reports and the weakness of some paperwork put forward for disciplinary hearings.

1.36 The claim by some that young people were driven to make allegations by the lure of compensation is not borne out by the evidence. Fewer than a fifth of those who were interviewed by internal investigators had by March 2009 made compensation claims. The statistics suggest that the convictions of the teacher and the unit manager following their Court cases in 2006 precipitated compensation claims.

Disqualification from working with children

1.37 A further outcome of the Glasgow investigation was that 31 ex-Kerelaw employees were referred to the Disqualified from Working with Children List (DWCL). Of these, 9 had been listed and 16 not listed by the end of 2008. Six remained provisionally listed. The emergence of such a large number of referrals early in the existence of the DWCL was as unexpected as the process was new to all concerned. The Council did not investigate some referrals as the individuals concerned had left their employment and there were significant difficulties in relation to such uninvestigated referrals.

Lessons learned by Glasgow City Council

1.38 The Council reported in 2007 that steps had been taken to improve the safeguarding of young people in residential care as a result of their findings in relation to Kerelaw and that an action plan had been drawn up to deliver further improvements. The Kerelaw Action Plan was subsumed into the Council's overarching Safeguarding Action Plan. Some tasks had been completed by the end of 2008 and others were ongoing. Work remains to be done on the central monitoring and scrutiny of complaints, but there has been welcome progress.

1.39 There is a *Listening to Children Strategy*, but there is pressure on the Children's Rights Service, which raises concerns about resourcing. A *Corporate Parenting Strategy* sets out how the Council and its partners will assume collective responsibility to meet the needs of looked after children. There is a Champions Board of elected members and senior officials, and the strategy clarifies the role of corporate management in monitoring and evaluating outcomes for Glasgow's looked after children. This was lacking in relation to Kerelaw and is a positive development. It appears that efforts have been made to improve residential care and promote safe care priorities, and the Inquiry heard references to a reflective self-evaluation culture beginning to develop. The Inquiry welcomes these positive signals and the arrangements the Council told us they have put in place to monitor, support and, where necessary, challenge contemporary practice.

Analysis and conclusions

1.40 The Inquiry concludes that abuse of young people did take place at Kerelaw after 1996 and that physical abuse was prevalent, although it did not involve all staff. Weaknesses in TCI training contributed to poor practice that was often abusive. The circumstances that allowed abuse to happen comprised a complex mix of cultural factors, including an over-emphasis on control. There were cliques and factionalism and inappropriate relationships which inhibited challenge and attempts at change, for which there was limited capacity.

There was a lack of strategic direction, both in Kerelaw and in Social Work HQ, and no united sense of purpose. Training did not support culture change as there was no shared view of the kind of organisation Kerelaw should be. There was no robust system for performance management and supervision of staff was inadequate. The complaints system was inconsistent and poorly monitored and there was little follow-through from fact-finding investigations of young people's allegations. Inspection did not stimulate culture change at Kerelaw. Criticisms that were made were insufficiently followed through by Kerelaw, the Council or, until after 2003, the inspection agencies.

1.41 Glasgow City Council's stewardship of Kerelaw was lacking in important respects. local government reorganisation created serious financial problems for the Council and distracted senior managers from the real issues at Kerelaw. External management was inappropriately delegated and inadequately carried out. Poor professional relationships at senior level in the Social Work Department compounded the problem. Proposals for the redevelopment of Kerelaw were a long term aspiration from 1996 onwards which may also have been a distraction. The Council's investigations from 2004 onwards were robust, but could have been better handled, and would have benefited from closer quality control of documentation. Staff were not well supported during the investigations and disciplinary processes. The quality of information management by the Council and the adequacy of records relating to young people in care were a cause for concern. Overall, there was a significant failure in leadership and management that led to the relative neglect of Kerelaw and, as a consequence, the dual abandonment of those who lived and worked there. That failure did not occur only in Kerelaw's final years: it grew over many years under changing circumstances and different management regimes.

Recommendations

1.42 Residential child care has moved on since Kerelaw and the protection afforded to young people is being improved. There is no room for complacency, and our recommendations build on those developments. All the strategies in the world will not prevent mistakes or failures. The best protection we can offer young people in care is that everyone, from front line care workers to the most senior managers, takes their responsibilities fully on board, puts the client first, and does their job.

Our recommendations include:

- **Improving leadership and management capability** by better succession planning; effective recruitment of high calibre candidates; clarifying roles and responsibilities for external management; and accountability for the monitoring and quality assurance of reporting systems.
- **Enhancing performance management** by introducing personal performance planning for external managers and the heads and other senior managers of residential establishments, and consideration of peer and subordinate appraisal processes.
- **Reinforcing the requirements of good supervision** underpinned by a supervision policy for every provider and consideration of group-based supervision.

- **Better training and learning** in mixed groups with appropriate reflection and evaluation of the learning experience; resourced to ensure underpinning of the SSSC registration requirements; and with guidance and refreshing of training in crisis intervention to ensure understanding and appropriate application.
- **Improving the avenues for listening to children** including easily understood and accessible complaints procedures; effective monitoring and review of complaints; and adequately resourced children's rights and children's advocacy services.
- **More rigorous follow-up to inspection** by service providers, external management and inspection agencies; and the transfer of historic inspection information to new inspection bodies.
- **More effective investigation and disciplinary processes** conducted jointly with the police where there is the possibility of crime; and based on sound legal advice and up-to-date expertise in employment law.
- **Good record-keeping** to underpin effective investigation and discipline and to afford looked after children the dignity and respect they deserve.
- **Competent referrals to the DWCL and registration bodies** based on thorough and efficient investigation to ensure those who should be disqualified from working with children are disqualified quickly and efficiently.

2. BACKGROUND

2.1 The Inquiry was commissioned by the Scottish Government and Glasgow City Council, following a report prepared by the latter in August 2007 on the outcome of investigations into allegations of child abuse at Kerelaw Residential School and Secure Unit in Stevenston, Ayrshire. The School had closed at the end of 2004 and the Secure Unit in March 2006.

2.2 In April 2006 two former employees at the school were convicted on a number of historical charges of child abuse, including sexual elements, and received prison sentences. Glasgow City Council concluded that a core of around 40 staff had been involved in abuse over a period of some 25 years and that a much larger number of staff knew about the abuse and did nothing to stop it. A number of former employees at Kerelaw were disciplined, and some were dismissed. Some were referred to the SSSC and the General Teaching Council for Scotland (GTCS) and to the Disqualified from Working with Children List (DWCL). Some of those referred to the DWCL were listed.

2.3 The conclusions drawn by Glasgow City Council attracted significant criticism, from those who were the subject of investigations and disciplinary procedures, from their families, and from others who had worked at Kerelaw over the years and who felt their reputation had been tarnished. Many criticised the lack of detail in the Glasgow Report. The Inquiry was announced by the Minister for Children and Early Years in November 2007, with work scheduled to start in January 2008.

Terms of reference

2.4 The purpose of the Inquiry was:

To secure comprehensive insight into the circumstances that led to the abuse that occurred at Kerelaw open and secure school from April 1996 until closure.

To examine Glasgow City Council's stewardship of Kerelaw School.

To consider the investigation by Glasgow City Council and post-school closure arrangements.

To make recommendations relevant to ensuring that the contributory factors which led to abuse at Kerelaw occurring and remaining unactioned for a protracted period cannot happen again.

To identify any other issues arising in the course of undertaking the Inquiry considered to be relevant to the safe care of young people in residential settings.

2.5 The terms of reference are set out in full at Annex A.

The Inquiry Team

2.6 The team comprised the Chairman, 3 other investigators – Dr Ingrid Clayden, Katie Lamb and Simon Glassford, and an office manager/administrator, Evelyn McKenna.

3. INTRODUCTION

Approach to evidence-taking and confidentiality

3.1 It was recognised when the Inquiry was set up that encouraging former Kerelaw employees and residents to give evidence was likely to be a challenge. For many, the prospect of giving evidence again, having already done so to internal investigators and the police, was likely to be daunting. It also seemed probable that individuals would be more forthcoming with information if they could be assured that their names would not appear in the Inquiry Report and if evidence could not be traced back to them.

3.2 It was therefore decided at the outset that the Inquiry would take place in private, and that the report at its conclusion would be anonymised. The terms under which information would be gathered in evidence were summarised in what we called by way of short-hand “rules of engagement” and were provided to those who were willing to give evidence, as well as to those whom we had hoped to interview, but who declined or did not respond. The terms under which evidence was gathered are reproduced at Annex B.

3.3 We also decided that we were more likely to have productive engagement with those who were willing to give evidence if we followed the example of the Edinburgh Inquiry¹ by adopting an inquisitorial rather than an adversarial approach to interviewing. Our aim was to understand individuals’ experiences of Kerelaw, and to address key themes in as open-ended a way as possible. This allowed those we interviewed to talk about their involvement with Kerelaw in their own way. It also allowed the Inquiry to consider a range of important matters, and enabled us to gain a helpful insight into a number of common themes.

3.4 It was anticipated that most interviews would be held in Glasgow and so it proved. Some took place in the Inquiry’s office in Edinburgh, or at the premises of organisations with a locus in the Inquiry. Some interviews took place in private homes. One interview took place in England.

Early work

3.5 Accommodation and services having been obtained in Edinburgh and Glasgow, work began in early 2008. Initial activity included the creation of a website, registration for compliance with the Data Protection Act, background reading and research, consideration of previous reports of inquiries into abuse, and contact with a number of organisations and individuals with an interest in, or experience of, the issues concerned. Some of those individuals became part of an informal expert advisory group and their advice was of considerable assistance to the Inquiry. We are grateful for their counsel. Thanks are also due to the Scottish Institute for Residential Child Care (SIRCC) for its helpful offer of access to its library resources. As part of our preparations, the Inquiry team visited the Kibble Care and Education Centre in Paisley and Ballikinrain residential school at Balfron, and we are grateful for the welcome we received.

¹ Marshall/Jamieson/Finlayson *Edinburgh’s Children: The Edinburgh Inquiry into Abuse and Protection of Children in Care* (1999)

Files and records

3.6 Cooperation and access to Council files were pledged by the Leader of Glasgow City Council, and early contact was made with senior officers to make the necessary arrangements. An employee of Glasgow City Council who was familiar with the Kerelaw files was identified, both as a facilitator of access to the records, and as the single entry point to Glasgow City Council for internal contacts, including contact with former Kerelaw employees.

3.7 While we were able through that route to access a large number of files, not all the records of senior management meetings or of communications between Kerelaw and Glasgow City Council Departments were traceable, and some took a considerable time to be unearthed. As a consequence of the closure of Kerelaw between 2004 and 2006, and of the lengthy investigations, files were kept in a very large number of boxes in Centenary House, Glasgow. Those files had been used by Council investigators, the police and legal representatives, and had to a large degree been disturbed, which made retrieval and systematic examination difficult. Some of the records were on “floppy” discs and zip files, which required to be accessed through non-standard computer hardware.

3.8 We were concerned about the quality of some of the information provided by Glasgow City Council. We had expected that statistics showing, for example, a breakdown of residents by age, length of stay, and placing authority would be readily available to enable the Inquiry to consider trends and validate a generally held view that the proportion of residents from Glasgow increased substantially in 2002 and 2003. We did receive raw data showing dates of birth and admission data, but were not able to draw safe conclusions from the figures.

3.9 The Inquiry read records of interviews by Council investigators with over 90 residents or former residents of Kerelaw, and over 100 employees or former employees, plus reports of investigations and records of subsequent disciplinary proceedings. A number of documents were made available electronically. As indicated in the Terms of Reference, the Inquiry did not have access to Crown Office or police files or statements, although meetings did take place with Strathclyde Police in Ayr and the Procurator Fiscal from Kilmarnock.

3.10 The Inquiry examined files held by HMIE, the Social Work Inspection Agency (SWIA) – the successor to SWSI - and the Care Commission. We obtained copies of reports of inspections of Kerelaw undertaken by North Ayrshire Council.

Oral evidence – former Kerelaw employees

3.11 We were aware at the outset of the strength of feeling among many former employees at Kerelaw about Glasgow City Council’s investigations into the allegations of abuse which erupted in 2004 and later, and about what the Council subsequently put into the public domain about its findings, as well as how these were portrayed in the media. Some former employees or their supporters made early contact with us to put their point of view, as did a very small number of ex-residents. Some former senior Kerelaw managers maintained a regular flow of information to us throughout the Inquiry.

3.12 Contact with former managers or staff at Kerelaw who were still employed by Glasgow City Council was made through the latter and individuals were encouraged to give evidence to the Inquiry. Some elected not to do so, or simply declined to respond. We learned that some may not have received our invitation to be in touch, and where we were able, we sought to reach them by other means.

3.13 As data protection requirements prevented the Council from passing on private addresses of its former employees, it was agreed that the Council would send letters to about 200 people at their last known home address, enclosing a letter from the Inquiry inviting them to contact us. Again, this had mixed results, with some former employees reluctant to give evidence while others were no longer at the address to which letters were sent. In total, we interviewed 11 former managers, 32 former care workers, 6 former teachers, plus several administrative staff and others.

3.14 North Ayrshire Council identified on our behalf 15 former domestic staff which it employed at Kerelaw and wrote inviting them to contact the Inquiry, but unfortunately we had no response. Other contacts were pursued directly by the Inquiry team. Overall, the Inquiry interviewed 55 former Kerelaw employees, including 5 former Principals or former acting Principals, and other ex-members of its senior management team.

Oral evidence – Glasgow City Council

3.15 The Inquiry also received oral evidence from one former and two current Glasgow City Councillors, and former senior managers in the Council's Social Work Department, including people directly and indirectly involved with the external management of Kerelaw from 1996. We interviewed former and current senior corporate managers in the Council, including the current Chief Executive. We interviewed all but one of the joint investigation team plus those who carried out the Millerston investigation (paragraphs 7.17-7.20) in the Spring of 2004.

3.16 Discussions took place with a focus group of current residential managers in the Council, and with a group of placing social workers. We interviewed a number of people in the HR, Finance, and legal functions in the Council, who had involvement with Kerelaw in relation either to policy or to the Council's investigations and/or disciplinary actions against staff. In total, we interviewed 35 current or former Council managers, including 5 who chaired disciplinary hearings.

3.17 We were disappointed not to be able to obtain evidence, even in written form, from one ex-Director who during the period covered by the Inquiry had at different times been both Director of Social Work and Director of Education at the Council and who had been involved in the decision to close the school.

Oral evidence – former Kerelaw residents

3.18 Various approaches were adopted for contacting former residents. At the outset we received advice cautioning us that writing to them, even if it were possible to obtain the correct addresses, would in all probability be unproductive. We were aware that many people who had been in care were likely to wish to put the experience behind them. We were also aware that, even if that were not the case, many would find it difficult to re-live what may have been a difficult time for them.

3.19 We were further advised that Glasgow City Council's joint investigation team had themselves found it difficult to get some young people to talk to them. Although, prior to the investigations, some existing residents' reluctance was because they were fearful of the consequences of complaining while still at Kerelaw, a later problem arose from the fact that many would have been asked to go over ground they had already covered in interviews with the police, and could not understand why information already given to the latter was insufficient (statements to the police were not provided to the Council's investigators).

3.20 This became still more of an issue after the Crown decided to not proceed against most of the 20 staff members who had been subject to police investigation and on whom reports had been submitted to the Procurator Fiscal. Although the Procurator Fiscal offered to meet with each of those who had made allegations and given police statements, to explain the reasons for the decision not to proceed, only one meeting was actually requested. The person concerned ultimately changed his mind at the point when the Procurator Fiscal attended to speak to him. The Inquiry learned that it is the practice of the Procurator Fiscal in such cases to offer to meet with those alleging abuse and explain the decision. If the offer is not taken up, Procurators Fiscal will respect the wishes of the individual not to meet. However, the effect of the decision not to proceed is that some of those interviewed by the police may have thought that they had not been believed.

3.21 We were aware that we could not rely on details on the Inquiry website to encourage former residents to make contact, and writing to them was not a practical option. Data protection considerations apart, as Kerelaw Open School had been closed for over 3 years and the Secure Unit for 2 years, it was likely that many addresses would no longer be accurate. As it seemed possible that some former Kerelaw residents might still be in contact with social services, as a first step we sought the support of local authority social work departments around Scotland in identifying and encouraging people to get in touch.

3.22 We also wrote to key charities seeking their assistance with contact. We held discussions with Barnardo's, whose street team services had been engaged by Glasgow City Council to provide support to former residents cited as witnesses in the Court cases in 2006 involving two members of staff. We also asked local authorities and the charities concerned if they would carry on their websites a link to the Inquiry website.

3.23 Those contacted responded with a willingness to help at least with the web link, and some authorities noted that they had not at any time placed children at Kerelaw. Despite their co-operation, these efforts yielded few contacts overall. We also followed up leads through individuals who had given evidence to the Inquiry, and we commissioned from Radio Clyde in September 2008 an advertisement which was broadcast over 3 days encouraging former residents to come forward. This was followed by a Press Release issued to local newspapers mainly in the West of Scotland, and we also secured a short item on Radio Scotland's Good Morning Scotland programme. Although some former residents and staff did make contact as a result, the overall response was less than we had hoped.

3.24 In addition to advertising, a member of the team met with the Heads of Children and Families and Criminal Justice in each of Glasgow's 5 Community Health and Care Partnerships (CHCP) to obtain their co-operation in a review of over 300 case files for young people who had been placed at Kerelaw by Glasgow City Council from 1996 until closure, with a view to identifying any live contacts who might wish to give evidence. This took some

time, and over 70 young people were contacted and provided with the details of the Inquiry. Where there was significant ongoing live contact with social services, efforts were made to encourage engagement with the Inquiry process, but the response was disappointing.

3.25 By mid-December 2008, when the Inquiry closed its formal evidence-taking, a total of 22 ex-residents had provided oral evidence. A further 12 interviews which had been arranged did not go ahead because those concerned did not keep their appointments. We also interviewed the parents of 2 young people who had been in Kerelaw. The Inquiry received very useful evidence from Children's Rights Officers (CROs) involved with Kerelaw over a number of years, from others who had relevant resident contact and, as noted earlier, we had access to a substantial number of notes of interviews conducted by Council investigators.

Oral evidence – others

3.26 Oral evidence was also provided by individuals in local authorities other than Glasgow which had placed young people in Kerelaw, by the Scottish Government and by a number of professional service providers at Kerelaw. Unison and the EIS also gave evidence. We were able to meet members of the Care Commission and representatives of HMIE. Unfortunately, we were not able to obtain oral or written evidence from a key former senior SWSI inspector with whom contact was made. A list of sources of evidence, in the case of individuals excluding their names, is given at Annex C.

Written evidence

3.27 Written evidence was provided to the Inquiry by a number of individuals, including former employees, and 2 former residents, and the partner of a former resident. Unison provided a written submission in addition to its oral evidence. There was also some input from academic researchers. Sources of written evidence are included in Annex C. The Inquiry is grateful to all those who gave evidence and everyone who otherwise gave generously of their time in discussion with us. It was apparent to us that, for many former managers, staff, ex-residents and investigators, talking about their time at, or involvement with, Kerelaw was a difficult and painful experience.

Confidentiality

3.28 In accordance with the Inquiry's undertaking to those giving evidence, we do not in the report identify which individuals told us what, although we do indicate the broad source, such as ex-employees, young people, managers, or external agencies and workers. Our terms of reference noted that our report would be anonymised as regards former members of staff and pupils at Kerelaw, and we have followed that approach, although it is necessary to refer to particular management positions both in Kerelaw and in Glasgow City Council. As at the time of writing one former employee is appealing against his conviction and sentence, we have taken care to limit any references to a statement of publicly verifiable fact as to the charges on which he was tried, and to how they arose.

3.29 We did not tape-record our interviews with those who gave us evidence and we did not write verbatim records. Where we highlight *in italics* views expressed by witnesses, we use the reported speech in which our notes of interviews were written. Throughout the report, we use the words "children" and "young people" interchangeably.

4. KERELAW RESIDENTIAL SCHOOL AND SECURE UNIT

The School

4.1 Kerelaw was situated in Stevenston, 28 miles from Glasgow, near the north Ayrshire coast. It opened in 1970, becoming a “List D” School shortly afterwards under Scottish Office Circular SW/11 of 1972. Initially, Kerelaw had residential accommodation for 72 boys, mainly between the ages of 13 and 16. In 1983 a closed, Secure Unit designed for a maximum of 18 young people in mixed sex accommodation was added and took in its first occupants in 1985. This was extended in 1988 to cater for 24 young people - 16 boys and 8 girls.

4.2 Like other List D schools, Kerelaw was initially funded jointly by central and local government. In 1983 the Fides Report into List D schools recommended that funding responsibility should transfer fully to local authorities and this was effected by 1986. From then until 1996, when it was taken over by Glasgow City Council, Kerelaw was the responsibility of Strathclyde Regional Council. In its early years almost all pupils came from Strathclyde Region, although it did admit pupils from elsewhere from time to time. Later, Kerelaw enrolled up to 12 day pupils. By 1996, when Glasgow City Council took over, the capacity of the Open School was 26 residential places for boys and 24 for girls aged between 13 and 17, along with 12 day pupils and the 24 residential places in the Secure Unit, making it Scotland’s largest residential school at that time.

4.3 Although operating on a single site under the management of one Principal, Kerelaw had after 1983 two seemingly distinct operations: the Open School and the Secure Unit. The Open School comprised 4 units – Baird, Millerston, Wilson and Fleming; the Secure Unit 3 - Stuart, Bruce and Wallace.

4.4 All units in the Open School were of a similar design with bedrooms upstairs and living and recreational facilities on the ground floor. Each unit had kitchen, laundry and dining facilities and one or two adjoining flats generally used for throughcare. For some time after Kerelaw opened, young people in the Open School were required to share rooms, although this was phased out gradually to enable all to have individual rooms. Initially, the Secure Unit accommodation was mixed, with both boys and girls in each of the units. However, after 1998 it was reorganised to provide single-sex accommodation for girls in Stuart unit and boys in the others.

The residents

4.5 Young people were usually placed at Kerelaw under a Supervision Requirement from a Children’s Hearing. Others were remanded or placed by the Scottish Executive following sentencing by the Court. Many had been accommodated previously. In 1997 Kerelaw was described as offering short- and longer-term placements to a wide range of young people with problems, with referrals being responded to on the basis of need within the terms of Glasgow City Council’s Joint User Agreement with other former Strathclyde Region local authorities. At that time, average admissions for a year ran at 100 or more, with 40% of these being crisis situations.

Education

4.6 In 1997 all young people at Kerelaw had access to education in English, Maths and Science – all of which were compulsory in the Open School and available up to Standard Grade. Other subjects offered in the Open School were Home Economics, Physical Education, History, Geography, Craft and Design, Art and Design and Keyboard Skills. Young people in the Secure Unit had access to Life Skills, Modern Studies and Religious Education. Attendance at school was compulsory for all residents of school age and all of those in the Secure Unit regardless of age. Each resident had a key teacher. Class sizes were small, with a maximum of 4 per class in the Secure Unit and 6 in the Open School.

Specialist interventions

4.7 In addition to residential care and education, Kerelaw provided young people with a variety of specialist interventions from full-time and visiting specialists. These included forensic psychiatry, forensic psychology, educational psychology, addiction care and counselling. Young people had access to General Practitioners and a practice nurse at the local health centre in Stevenston.

Purpose

4.8 A 1997 statement of Kerelaw's functions and objectives provides information on the Open School, the Secure Unit and on education. The "Values and Philosophy" of the Open School were described thus:

Whilst the principles of Skinner² form the backdrop other core values and themes have been consciously promoted to achieve a more thriving and productive atmosphere within the centre:

- *Purposeful involvement with young people at every level*
- *Positive approach to care planning and individualised packages of support*
- *Collaboration within and outwith the centre*
- *Delegation and accountability to unit level*
- *Partnership within and between units and disciplines and with young people (with listening and tuning into feelings becoming more central to addressing problem behaviour)*
- *Flexibility and responsiveness in the face of changing needs and situations*
- *Professional pride and achievement supported by a knowledge base and supervision*
- *Awareness of the role of residential care within a wider spectrum of resources and skills*
- *Gender consciousness and anti discriminatory practice*
- *Regular and frequent contact with young people's families and/or localised support systems*
- *Ownership and responsibility of the caring task at every level*
- *Child protection and safe caring at the level of the individual and group*

² Skinner, A *Another Kind of Home : A Review of Residential Child Care* SWSI Edinburgh (1992)

4.9 Each of the units produced a development plan within an overall management plan for the Open School, with key themes of diversity in the education programme, offence related work, employment, throughcare, child protection and staff development. The Secure Unit shared the overall aims and objectives of the Open School, but was described as providing long- and short-term care for highly disturbed and dangerous young people. Security was based on the principle that the creation of a positive treatment regime would reduce the likelihood of planned attacks on security. Kerelaw said it aimed to cultivate in its Secure Unit staff an attitude to security that was unobtrusive, but thorough, watchful and careful at all times.

4.10 In 2001, information about Kerelaw provided to young people and their carers stated:

*We aim to provide high quality residential care with education
We try to minimise the difficulties of our clients and build on their strengths
We aim to reintroduce our clients into society with acceptable lifestyles*

4.11 By 2003, Kerelaw had produced a Mission Statement covering the Open School and Secure Unit:

Kerelaw School and Secure Unit provide structured programmes of social education for young women/men who require either a placement in a residential school or placement in a secure care setting and have gone through the relevant processes for admission.

All young people are recognised as individuals who have potential. We aim to maximise the potential of individuals and enable them to take up their full citizenship upon discharge. Working together with young people, their parent(s), carer(s), case-holder and significant others, we aim to provide opportunities for young people to address their problems and to receive appropriate specialist support in order to internalise the learning.

The ethos of the School and Secure Unit is one of working positively with young people through the development of constructive and reparative relationships. Focused and targeted programmes of work can only take place within the context of stability and trust. We aim to build trust as our first priority in order to be able to make a positive difference to the lives of the young people in our care.

Kerelaw School and Secure Unit is committed to making the environment as safe as possible for young people. We recognise that there is a problem with bullying across society and this is a particular problem in institutional living. We are committed to ensuring that anti-bullying strategies have a high profile and that adults take a lead in promoting a positive culture at the same time as dealing proactively with incidents.

We strive to create a culture and atmosphere where young people feel valued and have the opportunity to work through their present difficulties and are encouraged to plan for their future needs with the full support and encouragement of the staff group.

Profile

4.12 The Inquiry had some difficulty sourcing accurate and comprehensive data from Glasgow City Council on the profile of Kerelaw. We received incomplete records of those who were resident at Kerelaw during the period covered by the Inquiry and historic records of staffing that largely predated 1996. We made use of what data we had, together with published statistics on residential care in Scotland, to put Kerelaw in context. To that end we focused on 2000 – the mid-point of the Inquiry period – to describe the profile of Kerelaw. We appreciate this picture is incomplete, and that there were trends and potentially significant changes both earlier and later in the period.

Residential care in Scotland in 2000

4.13 Scottish Executive statistics³ show that in Scotland at 31 March 2000 there were 205 residential establishments for young people, including children's homes, hostels, homes for children with disabilities and residential schools (including secure accommodation), providing 2,273 places and employing 4,220 staff. Across this broad range, the average establishment size was 11 places – roughly equivalent to one of Kerelaw's 7 units - with an average of 1.9 staff to every place. Around 13% of all establishments, residential places and their staff in Scotland were provided in the Glasgow City Council area, while the population of 10 to 20-year olds in Glasgow represented only 11% of Scotland's total in the April 2001 census.⁴ This difference may be explained in part by the fact that at 31 March 2000 Glasgow City Council was looking after 19 children per 1,000⁵ population aged 0 to 17 compared with the national average of 10 per 1,000. This gives some insight into the scale of the task facing the Council's Social Work Services.

4.14 Of the 205 residential establishments in 2000, there were 32 residential schools providing 1,037 places, including secure places, for young people. This figure remained relatively static over the period up to 2004. Five of these residential establishments were local authority-run, accounting for 145 places in 2000, although by 2004 there were only 102 places in local authority-run residential schools, with 935 in places provided in the private/voluntary sector. In 2000, Kerelaw's 74 places made up just over 7% of Scotland's total provision of residential school places for children of all ages and 51% of Scotland's total local authority-run residential school and secure unit places.

Young people in care in 2000

4.15 On 31 March 2000, 1,973 young people were accommodated in all types of residential accommodation and about two-thirds of accommodated children (1325) were boys. Two-thirds were in the 11 to 15 age group and nearly a quarter (459) were aged 16 or over. Seventy five percent of young people discharged from all residential accommodation during 1999-00 were there for less than one month and 12% for between 1 and 6 months. A further 5% of young people were accommodated for between 6 months and one year and the remaining 8% were accommodated for more than a year. Around half of these young people (911) were accommodated in residential schools and secure units with occupancy rates of 97% and 86% in local authority-run and privately/voluntarily run schools respectively, and throughput in local authority-run schools averaging around 3 times the throughput in others

³ <http://www.scotland.gov.uk/Topics/Statistics/Browse/Children/PubChildrenResidential>

⁴ <http://www.gro-scotland.gov.uk/statistics/publications-and-data/population-estimates/popprep/popprep11.html>

⁵ <http://www.scotland.gov.uk/Topics/Statistics/Browse/Children/PubChildrenLooked After>

(2.5 admissions per place compared with 0.7). These data suggest that the management challenge of introducing new residents while maintaining a stable environment in residential schools was substantially greater for local authority places, half of which were at Kerelaw.

4.16 In 2000-01, Scotland's secure estate comprised 94 places. This figure remained static through to 2004, having risen from 86 places between 1999 and 2000. In 2000-01 there were 218 admissions and 212 discharges from secure places in Scotland. Average occupancy was 90% of capacity, with a range of 79% to 99%. At that time, Kerelaw's 24 beds made up around a quarter of Scotland's secure provision for young people. This contribution fell to 20 beds for 2004-5 and to zero when the Kerelaw Secure Unit closed in March 2006. Overall provision was maintained by the addition of single-bed spaces in other units during 2004-05 and the opening of St Phillips, with 24 beds, in March 2006.

Young people placed at Kerelaw

4.17 The young people placed at Kerelaw had social, emotional and behavioural difficulties. As a result, many had problems with drug and/or alcohol use. Many had been involved in offending. Their education had often been disrupted, sometimes due to frequent moves of house as a result of family breakdown, and sometimes due to their having been excluded from school. From the files we read and the people we spoke to, the Inquiry formed the impression that the young people placed at Kerelaw came from backgrounds characterised by adversity and/or abuse.

4.18 Young people often came to Kerelaw following a crisis in another care placement, as we note at paragraph 12.22. This usually followed episodes of challenging behaviour, such as aggression and violence towards staff or other young people, drug or alcohol misuse, or offending. Many of the young people self harmed. We heard from one mental health professional of the overwhelming mental health needs of the young people at Kerelaw.

4.19 The files seen by the Inquiry suggest that most of the young people placed at Kerelaw had some contact with their families. They had regular home leave. However, there were some who had no ongoing contact with their birth families and for them Kerelaw was home. We heard from staff that, in recognition of this, they tried very hard to make weekends different for this group. Indeed, some staff suggested that the increase in young people being admitted on a respite basis (see paragraph 12.25), was particularly disruptive and unfair to the group of young people who lived at Kerelaw.

4.20 Fieldwork files sampled showed that most of the young people had lengthy backgrounds of social work involvement. Many had been subject to supervision requirements as young children and some had been on the child protection register. There were examples of family breakdown, bereavement and parental substance misuse.

4.21 In summary, the young people placed at Kerelaw had usually been involved with social work services from a young age due to family problems. They had often suffered abuse and already been in other care placements. As a result, they presented with complex difficulties and would have been a challenging group to care for. With such large numbers it would have been extremely difficult to ensure they were offered the individual care they needed.

Residential school staffing in 2000

4.22 On 31 March 2000, there were 1,870 staff in residential schools with the majority (1,611) working in the private/voluntary sector and the other 259 in local authority establishments, giving an overall staff to residential place ratio of 1.8:1. This is slightly lower than the overall average staffing ratio in residential care (1.86:1), as may be expected in these generally larger establishments. Between 2000 and 2004, the ratio of staff to places in residential schools increased substantially, so that in March 2004 there were 2,608 staff for 1,037 places – an average of 2.5 staff for each place overall, with 2.2 staff for each local authority place and 2.5 staff for each private/voluntary provided place.

4.23 According to figures provided by Glasgow City Council, in 2000 Kerelaw had a budgeted establishment of 109 residential staff comprising 37 Secure Unit staff, 37 Open School staff, 24 night staff, 2 day unit staff, 3 managers and 6 administration staff. Of these, 100 posts were established and the remaining 9 were temporary. In addition, there were 19 teaching staff divided between the Open School and Secure Unit, giving an overall staff to residential place ratio of 1.7:1, which was not atypical of residential schools at the time, despite Kerelaw's more challenging resident population.

4.24 Each of the units in the Secure Unit was staffed by a unit manager, a deputy unit manager and 10 residential workers. Of these 36 staff, 13 were female, including the unit manager and 5 residential workers in Stuart – the girls unit. There were 4 male and 2 female night staff across the Secure Unit. In each of the Open School units there was a unit manager, a deputy unit manager and 7 residential workers. Of the two girls units, Wilson unit was staffed by a male unit manager and 8 female staff and Baird unit by a female unit manager with 2 male and 6 female staff. Each had 1 male and 3 female night staff. Of the two boys units, Fleming unit had a male unit manager and 7 of the other 8 staff were also male, while Millerston had a female unit manager supported by 6 male and 2 female staff. Fleming unit had 3 male and one female night staff and Millerston had 2 male and 2 female night staff. Taking into account the day unit staff and additional staff (2 male, 2 female) the overall ratio of male to female residential staff across Kerelaw when the budget was reported in 2000 was 45:55, although in unit and senior management positions men predominated.

Management structure and accountabilities

4.25 In 1996, when Glasgow City Council became responsible for Kerelaw, its senior management structure was a Principal/Headmaster, a Deputy Head in charge of the Open School, sometimes referred to as Deputy (Social Work), a Deputy Head in charge of the Secure Unit - also sometimes referred to as Deputy (Social Work) - and a Deputy responsible for Education across both the Open School and the Secure Unit. For the purposes of this report and for ease of reference, we shall call the members of this senior management team (SMT), the Principal, the Deputy (Open School), the Deputy (Secure Unit), and the Deputy (Education).

4.26 Within Kerelaw the 3 Deputy Heads reported to the Principal. The Deputy Head (Open School) had as direct reports 4 unit managers, while the Deputy (Secure Unit) had 3. From May 2003 an additional Deputy (Education) was appointed to the Open School. We were told that Administrative staff reported, sometimes via the Deputy (Open School), to the Principal.

External management

4.27 Following local government reorganisation in 1996, external management responsibility initially fell to the Manager of Glasgow City Council's North West District. Following the abolition by the Council of the district structure, it was taken over by the Head of Children and Families in the Social Work Department, who for the purposes of this report we shall refer to as Head of Service.

4.28 The Head of Service reported to a Depute Director, who in turn reported to the Director of Social Work. There was therefore a management line from the Director of Social Work to the Principal of Kerelaw. In practice, day-to-day external management was delegated to the level below Head of Service, and this was problematic, particularly in later years. There was in principle also a professional connection between education staff and the Education Department in the Council, but we were told that the Deputy (Education) had no separate reporting line up to senior education officials in the Department.

Inspection and regulation

4.29 A number of different bodies were responsible for inspecting Kerelaw School and Secure Unit in the period between 1996 and its final closure in 2006. These were: HMIE, SEHD, SWSI, and North Ayrshire Council Registration and Inspection Unit. From 2002 the Care Commission took over inspection responsibilities from North Ayrshire Council.

4.30 The Secure Unit and the Open School were subject to different inspection processes due to their different functions. When Kerelaw was managed by Strathclyde Regional Council, the Council's Registration and Inspection Unit carried out the monitoring and inspection of both the Open School and the Secure Unit. However, the Secretary of State for Scotland had to approve the secure accommodation, and was advised by SWSI, which inspected secure services for this purpose under the Secure Accommodation (Scotland) Regulations 1983. HMIE were responsible for inspecting the education provision in both the Open School and Secure Unit.

5. LOOKED AFTER CHILDREN LEGISLATION AND REGULATION

5.1 There were a number of changes in legislation and regulation between 1996 and 2006, not all of which need to be described here. Two - the Children (Scotland) Act 1995, and the Regulation of Care (Scotland) Act 2001 - are particularly important. The Protection of Children (Scotland) Act 2003 is also relevant and is referred to at paragraph 16.1 in relation to the Disqualified From Working With Children List (DWCL). The Children (Scotland) Act came fully into force on 1 April 1997, a year after the transfer of Kerelaw to Glasgow City Council. The Regulation of Care (Scotland) Act came into force a year before the eruption of allegations of abuse which ultimately led to Kerelaw's closure.

The Children (Scotland) Act 1995

5.2 The Children (Scotland) Act 1995 marked a significant change in legislation in respect of the care of children. It centred on the needs of children and their families and defined both parental responsibilities and rights in relation to children. It also defined the duties of public authorities in the support of children and their families, and their powers when a child's welfare required action to be taken. The Act followed a review of child care policy and law in Scotland and was informed by the findings of Inquiries into the removal of children in Orkney and child care policies in Fife.

5.3 The Act incorporated provisions conforming to the UN Convention on the Rights of the Child and was founded on the principle that each child had the right to be treated as an individual. It introduced changes in language to shape its provisions around the child. Legal terms such as "access" and "custody" were replaced with "contact" and "residence". Children were no longer "in care" but became "looked after". This terminology was introduced to reflect the commitment to working in partnership with parents.

5.4 The Act extended responsibility for looked after children from the social work department to a total local authority basis. As there was concern about the health and education of looked after children, it promoted greater inter-agency co-operation both within and beyond the local authority boundary. It also gave powers to local authorities to continue to provide advice, guidance and assistance to young people who had been looked after as children. Local authorities were also required to consult with other agencies and publish plans for the provision and development of services for children.

5.5 As noted at paragraph 5.1, the implementation of the Children (Scotland) Act took place only a year after local government reorganisation in 1996. While local authority social work services were still dealing with the upheaval of reorganisation, they therefore faced embarking on major retraining of their workforce. Among the extensive regulations and guidance related to the Act, care planning and external management arrangements would have been of particular relevance to Kerelaw.

Care planning

5.6 Local authorities are required to draw up a care plan for every looked after child to address their immediate and long-term needs. It must include details of the authority's intentions for the child, and the services which will be provided immediately and in the longer term to meet the child's requirements for care, education and health. The plan must

also note how the parents are contributing to the child's day-to-day care, the contact arrangements, and how long any placement is expected to last.

5.7 In 1997 the then Scottish Office piloted 'Looking after children in Scotland' materials. These were tools for information gathering, planning, assessment, and review in respect of children looked after away from home. They were adapted from materials introduced in England, which met the requirements of the Children (Scotland) Act, to improve the longer term outcomes for looked after children. They were based on 7 dimensions key to the development of children and young people: health; education; family and social relationships; emotional and behavioural development; identity; social presentation; and self-care skills.

5.8 Glasgow City Council introduced those materials in 1997 and we found evidence of their use when we read a sample of social work fieldwork files for young people who had been at Kerelaw. They were less in evidence in the Kerelaw files themselves, where a variety of different care planning formats seem to have been used. We heard a range of views on care planning from those from whom the Inquiry took evidence. For example, we heard that care staff at Kerelaw sometimes wrote the child's care plan without any input from the fieldworker. On the other hand, we also heard that Kerelaw had introduced care plans before there was any statutory requirement to do so (see paragraphs 12.36 and 12.37).

External management provision

5.9 The Children (Scotland) Act 1995 Regulations and Guidance Volume 2 outline the main tasks of the external manager:

- monitoring the experience of children;
- ensuring that practice complies with legislation, regulations and national and local guidance;
- supervising and supporting the person in charge;
- ensuring that staff are familiar with their responsibilities and equipped through training, to perform them;
- ensuring that resources, including staffing, the building, furnishing and fittings are sufficient and suited to purpose;
- identifying the need for and instigating any necessary changes; and
- reporting on progress to the managing authority or agency.

5.10 The external manager is defined as the person who holds overall responsibility for the services provided by the establishment. The primary responsibility, in conjunction with the person in charge, is to ensure that acceptable standards are maintained. The external manager is expected to be familiar with other monitoring arrangements, such as inspection reports, and also to visit the establishment to talk with and listen to children, parents and staff. There were significant failures in the external management of Kerelaw by Glasgow City Council after 1996, and we return to these in Chapter 13.

The Regulation of Care (Scotland) Act 2001

5.11 The Regulation of Care (Scotland) Act 2001 aimed to provide greater protection for those in need of care services. It established a system of care regulation, and created the Care Commission as an independent regulatory body. It provided for care services to be registered

and inspected against a set of national standards and for enforcement action where necessary. National standards were developed to achieve consistency in the quality of care provided and received throughout Scotland, and they set out the quality of service that users had the right to expect.

5.12 Before the Act, child care services were subject to a range of different regulations. For example, private and voluntary sector residential care homes were regulated by local authorities and secure accommodation for children by SWSI. Local authority run care homes were not subject to registration at all. Kerelaw was, however, inspected by North Ayrshire Council's Registration and Inspection Unit. Under the Act, all local authority care services had to register and meet the same standards as the independent sector. Secure accommodation also became subject to regulation by the Care Commission. As noted in Chapter 11, the Care Commission began inspecting Kerelaw in 2003.

5.13 The Act established the SSSC as an independent body to regulate the social services workforce and to promote and regulate their education and training. The role of the SSSC is to enhance the protection of people who use social services and increase public confidence in the sector by raising standards of practice. The SSSC promotes high standards of conduct and can take action when service users are at risk. Registration is a major part of the drive for higher standards and will bring the workforce in line with other professional service providers.

5.14 To register, workers must satisfy the criteria for registration. This includes holding the appropriate qualifications for the job they do and being able to evidence good character. When a social service worker applies to register, he or she must agree to abide by the Code of Practice for Social Service Workers, which sets out the conduct expected of such workers and informs people who use social services, and the public at large, about the standards they may expect.

5.15 The Register of Social Service Workers in Scotland opened on 1 April 2003. The Scottish Government decides which groups of workers the SSSC will register and in what order. A formal Commencement Order is laid before the Scottish Parliament to open each part of the Register. In September 2005 it became mandatory for social workers to be registered with the SSSC. The SSSC began registering managers of residential child care services in June 2005, residential child care workers with supervisory responsibilities in October 2005, and all other residential child care workers in July 2006. All residential child care workers will be required to be registered by September 2009.

Implications of legislation for Kerelaw

5.16 The Children (Scotland) Act may be described as having three over-arching themes:

- the welfare of the child to be paramount when his or her needs are considered by Courts and Children's Hearings;
- no Court should make an order relating to a child, and no Children's Hearing should make a supervision requirement, unless the Court or Hearing considers that to do so would be better than making no order or supervision requirement at all;
- the child's views should be taken into account where major decisions are to be made about his or her future.

5.17 Despite the importance of this legislation, its implications were seldom referred to in the interviews we conducted in the course of the Inquiry. Its visibility seemed to be low, and there was little or no evidence of an impact on Kerelaw. While some of those who gave evidence did acknowledge that there was an increase in advocacy staff such as CROs and Who Cares? workers visiting children in Kerelaw over the years, this did not lead to changes in day-to-day practice.

5.18 The Regulation of Care (Scotland) Act led to the Care Commission taking over the inspection of Kerelaw from North Ayrshire Council from April 2002. An important consequence of this was that inspection would henceforth be backed up by greater enforcement powers. Those powers were put into action following the inspection of Kerelaw in August 2004, as described at paragraph 11.6.

5.19 The SSSC has now finalised the process for registering residential child care workers. Registration will aim to ensure that residential child care workers are properly trained, qualified and of good character. Minimum qualifications have been set. Qualification levels in the sector have traditionally been low and we heard from many former staff at Kerelaw that when they started at Kerelaw, they had neither qualifications nor experience in working with children. However, many did go on to gain qualifications. As we note in Chapter 10, it was clear to the Inquiry that qualifications alone were not necessarily the key to better and safer practice.

6 POLICY TRENDS AND INITIATIVES

6.1 The Inquiry was told by former managers and staff at Kerelaw that over the years the young people placed there presented increasingly difficult behaviour. There is no doubt that during the 30-plus years of Kerelaw's existence there were major changes in the use of, and attitudes towards, residential child care. In the UK as a whole numbers of children in residential care peaked in the mid-1970s. In 1976 6,242 children were living in residential care in Scotland but by 2005 this number had dropped to 1,539 - see *Extraordinary Lives*, (2006)⁶. Numbers in foster care, however, remained relatively stable.

The decline of residential child care

6.2 Crimmens and Milligan (2005)⁷ suggested that by the beginning of the 1990s residential care was:

not only waning, it appeared to be in terminal decline.

and listed a number of important factors contributing to ambivalence towards the residential child care sector. These included the influence of the "anti-institutional" movement, the preference for placing children with substitute families rather than in residential units, and concern about rising costs. In addition, research in the 1980s revealed that social workers saw reception into care as a sign of social work "failure". Social work managers therefore directed their attention to developing alternatives to residential care. Practitioners received the clear message that residential care was bad, and by extension, not valued.

The impact of shrinking the residential child care sector

6.3 It was perhaps inevitable that the contraction of the residential care population would increase the complexity of the residential child care task. Children and young people placed in residential care might well have already been offered support in the community. In order to avoid too much use of this scarce and expensive resource, children were often expected to have worked their way through various tiers of intervention. Children with the most complex difficulties, the least resilience, and poor community and family supports became the group most likely to be placed in residential care.

6.4 Before being placed in a residential school like Kerelaw, children would probably already have been through a hierarchy of other care placements, such as foster care or smaller children's units. Many young people were placed in Kerelaw due to their experiencing difficulties in other units in Glasgow and elsewhere. A common sentiment was summed up thus:

all the kids who came to Kerelaw came as a last resort...

There was a view that Kerelaw was getting everyone who had failed elsewhere.

⁶ "Extraordinary Lives : Creating positive futures for looked after children and young people in Scotland" Social Work Inspection Agency Edinburgh (2006).

⁷ Crimmens, D. & Milligan, I. *Residential Child Care: Becoming a Positive Choice. In Facing Forward: Residential child care in the 21st century* Eds. Crimmens, D. & Milligan (2005) Russell House Publishing

Kerelaw was the pressure valve for Glasgow and the sponge soaking up the problems...

6.5 The Inquiry heard references of this kind from former Kerelaw staff and from residential child care staff in Glasgow's children's units. The sense of Kerelaw being a "place of last resort" was thus reinforced for children, placing social workers and residential care staff. While this put increasing pressure on Kerelaw staff, we also heard that many staff took pride in being able to cope with the challenge it posed and recognised that it was their job to cope.

Emergency admissions

6.6 Given the stringent gatekeeping arrangements for residential placements, more breakdowns in the community were likely to result, with the consequence that many children ended up at Kerelaw in an emergency. The lack of planning for individual children associated with this would also have affected the ability of the school to plan appropriately. An ever-changing population at the school would have brought with it a continuing sense of instability. We return to the placing of young people at Kerelaw at paragraphs 12.22-12.28.

"Another kind of home"

6.7 Concerns that residential child care was a poor second choice to community support developed into worry about its safety. Evidence of children being abused in residential institutions emerged and this thrust the issue of children in care on to the policy agenda. The Pindown report⁸ was published in 1991 and led to fierce public debate about how such a situation could have arisen. This in turn led to the Utting⁹ (*Children in Public Care* in England) and Skinner (*Another Kind of Home* in Scotland) reports, which were influential in moving residential child care back into focus. Both Skinner and Utting affirmed the possibility of considering residential child care as a positive option. However, more than a decade later it appears that there is still a struggle to make this a reality.

Safeguarding

6.8 When more concerns emerged about the potential for children to be abused when looked after away from home, the Government commissioned a review of safeguards. Reports were published in 1997 - in England Utting's *People like us: the report of the review of safeguards for children living away from home*¹⁰, and in Scotland, Kent's *Children's Safeguards Review*¹¹. Despite noting that some progress had been made, these reports concluded that there was still much work to be done. In particular the poor skill level of residential staff remained a major concern.

⁸ Levy, A. & Kahan, B *The Pindown Experience and the Protection of Children* The Report of the Staffordshire Child Care Inquiry. Staffordshire County Council (1991)

⁹ Utting, W *Children in Public Care : A Review of Residential Care* DOH London (1991)

¹⁰ Utting, W *People Like Us: the Report of the Review of the Safeguards for Children Living Away from Home* DOH London (1997)

¹¹ Kent, R *Children's Safeguards Review, Report for the Scottish Office Home Department* The Stationery Office Edinburgh (1997)

Outcomes and aftercare

6.9 As noted earlier, The Children (Scotland) Act 1995 promoted greater inter-agency co-operation, and widening the duties to looked after children to the responsibility of the local authority as a whole, rather than simply social work services. This reflected growing concern over the poor educational and health outcomes for looked after children.

6.10 There was also concern about how little support was given to care leavers. The Inquiry heard from a range of witnesses about the difficulties young people faced when they moved on from Kerelaw. At one point a dedicated throughcare and aftercare service was established at Kerelaw. This service involved semi-independent living on the campus and links to local employers. It was never properly funded or staffed and relied on overtime working. It did not remain in place for very long. Young people were referred to aftercare services in their placing authority and we did see evidence of some being well supported in their first steps to independence. However, we were also told about a lack of suitable accommodation for young people to move on to.

Youth justice

6.11 Many of the young people placed in Kerelaw were there, at least in part, because of their offending behaviour. There have been numerous policy changes in relation to youth offending over the past decade. Much of the activity has been around working with young offenders while they remain in the community. Specialist youth justice workers began to offer individual and group work programmes, often based on a cognitive behavioural approach. The Forensic Child and Adolescent Mental Health Service (FCAMHS) from Glasgow provided services within the Secure Unit at Kerelaw for a number of years.

6.12 The introduction of those programmes within the Secure Unit was the first time this had been done in that environment in Scotland, and Kerelaw deserves praise for its innovation. Staff were carefully selected and trained to carry out this work. Programmes were introduced in the Open School, but we were told that there had initially been some management resistance to this, and it seems there was no consensus view among employees as to the merits of such programme work.

Drug and alcohol use

6.13 Many people told us of the increasing number of children coming to Kerelaw who faced serious problems with their drug and/or alcohol use. This was also noted by community-based staff and by other residential care staff. Young people with problems of drug and/or alcohol abuse put considerable strain on group living. Within Kerelaw's relatively large units of 12 young people, it would have been a challenge both to ensure everyone was safe and to meet residents' support needs. Although Kerelaw employed specialist addiction counsellors who worked with young people on an individual basis, we were told that this service was not always welcomed by unit staff, and it was suggested that some blocked young people's access to the addiction workers. This was an issue in the Millerston investigation in 2004 (see paragraphs 7.17-7.20).

The National Residential Child Care Initiative

6.14 There has been a growing awareness that seeing residential child care as a residual, marginal service of last resort has unfortunate implications for the quality of that service. Children placed in residential care often feel stigmatised. Staff feel undervalued and recruitment can be difficult. Despite this, the orthodoxy of residential care as a failure of social work lingers on, even though some children and young people prefer residential to foster care. This requires further exploration, as the superiority of family placements is often taken as a given by practitioners, but it is outside the scope of this Inquiry to do this.

6.15 SIRCC has been commissioned by the Scottish Government to lead the National Residential Child Care Initiative (NRCCI). This will consider the challenges facing residential child care in Scotland and make recommendations for change with a view to making such care the first and best placement of choice for those children whose needs it serves. The aim of the NRCCI is to develop a blueprint for the development of residential child care in Scotland including:

An audit of and strategy for the supply of residential child care services to match the full range of needs of children and young people.

A determination of the right skills mix of professionals working in residential child care to ensure those working with these young people are well-equipped to support these young people to develop their full potential.

An agreement on expectations between local authorities and providers to ensure effective commissioning of services for these young people.

It will recommend to Scottish Government, local government and providers of residential child care the actions required to achieve consistent improvement across the residential child care sector.

6.16 The NRCCI will report on the key findings and make recommendations for Scottish Government, local government and providers of residential child care. These are to be presented to Scottish Ministers in 2009. We wish this initiative well and hope that the findings of the Inquiry will be helpful to its purpose.

Implications for Kerelaw

6.17 The decade covered by this Inquiry was one of major policy and legislative changes relating to children and young people. Throughout the Inquiry we heard from a range of people, from inside and outside Kerelaw, who considered the pace of change there was extremely slow. A number of people referred to Kerelaw having been in a “time warp”. Some took the view that having a large residential school run by a local authority was a dated concept, part of an earlier child care system. There is also evidence that some senior managers were either resistant to, or did not see the need for, change. Glasgow City Council made changes in their policy and procedures regarding residential child care over the period. However, it seems that Kerelaw was not always included in these changes and was often seen as a special case. We shall discuss issues of this kind later, but before doing so it may be helpful to explore the range and nature of allegations of abuse that led to this Inquiry.

7. RANGE OF ALLEGATIONS OF ABUSE

7.1 A report prepared by Glasgow City Council for the Minister for Children and Young People dated August 2007 (which we refer to as “the Glasgow Report”) noted that there had been between 350 and 400 allegations from 159 complainants and that:

The complaints and allegations upheld either through the Court process or the Council’s disciplinary processes, show that the majority of physical and sexual abuse can be attributed to around 40 individuals over a 30-year period. However, the investigations, through interviews with a range of staff and young people, also identified that a far larger number of staff had knowledge and information about abuse and potential abuse, which was not appropriately dealt with.

For practical reasons associated with tracking down potential witnesses the internal investigations on which the report relied were weighted towards alleged incidents in the 1990s and early 2000s.

Police investigations and Court cases

7.2 The police inquiry – named “Operation Chalk”, and which was conducted alongside, not jointly with, the Council’s internal investigations - resulted in April 2006 in the conviction of an art teacher and a unit manager on charges of physical and sexual abuse. The teacher had faced an indictment of 49 charges of assault relating to the period 1975 to 2003, including 2 joint charges with the unit manager. Of those, 18 were of a sexual nature or had sexual elements involving allegations of actual sexual contact with young people. The unit manager’s indictment covered 38 charges of assault on a number of occasions between 1983 and 2003, including the 2 joint charges with the teacher. Of those, 16 had a sexual element.

7.3 The teacher was convicted on 18 counts relating to incidents between 1975 and 1995, half of which contained a sexual element and related to the period 1977 to 1990. The unit manager was convicted of 4 charges containing a sexual element, relating to the period 1992 - 1994. The teacher was sentenced to 10 years’ imprisonment. He was released on interim liberation in December 2007 pending an Appeal which at the time of our writing this report had not been heard. With this Appeal outstanding it would be inappropriate for the Inquiry to make comment on the individual concerned or his conviction, other than to note that the police inquiry into the allegations against him did not arise from fact-finding by the Council’s internal investigators. No fact-finding in relation to him was carried out by the investigation team.

7.4 The unit manager was sentenced to 30 months’ imprisonment and served his time. Unlike the teacher, he had been subject to investigation by Glasgow City Council in relation to staff complaints about his management style and to allegations of abuse of young people. He was referred to the police along with a number of individuals following an internal report to the Directors of Social Work and Education in June 2004.

7.5 In total, 21 individuals were reported to the Procurator Fiscal, mainly for physical abuse of young people. Two of those were convicted, as noted above, in 2006. As a result of a police report not related to “Operation Chalk”, another individual, a night worker, had been

convicted in 2004 of physically assaulting a female resident. He had already been subject to a disciplinary procedure which resulted in a Final Written Warning, which was revisited but not changed after his conviction. He remained in employment with the Council but was then paid off. A fourth individual died. A female care worker at Kerelaw was also prosecuted, but was found not proven and acquitted in 2007 on charges relating to sexual relations with a minor while he was resident at Kerelaw School. This worker had previously been twice investigated, eventually disciplined by Glasgow City Council for gross misconduct, and dismissed. The Inquiry confirmed that by 2008 decisions had been taken by Crown Counsel following consideration of the report of the Procurator Fiscal not to proceed with any of the outstanding cases.

Allegations of abuse over the years

7.6 Kerelaw, like other child care establishments, was no stranger to complaints and allegations over the years, both before and after Glasgow City Council took responsibility in 1996. There is evidence that some of these were investigated, at least internally. Prior to 2004, a variety of concerns about how Kerelaw operated, about “what was going on” and about the behaviour of some of Kerelaw’s staff, had been expressed by external managers, by Kerelaw staff, social workers, and by others who had contact with the school. Again, some of these were looked into. However, none of these individual issues at the time sparked the scale of investigation subsequently undertaken by the Council. It is not possible to follow a single chain of events directly to the Council’s 2004 investigations. Rather, the evidence points the Inquiry to the coincidence of a number of related events, and a determination on the part of key individuals in and around Kerelaw to make themselves heard and to persist in ensuring that a thorough investigation was undertaken at last. Examples of relevant events are described below.

7.7 While the complaints system, as discussed at paragraphs 12.5-12.21, was inconsistent and in important respects deficient, it was used by some residents, and many complaints were followed up. A number of those involved complaints by non-Glasgow residents to their placing authorities. Between 1996 and 2000 a neighbouring local authority’s CRO became increasingly concerned about patterns of complaints about inappropriate restraint practices and physical assaults from young people placed at Kerelaw, and the unsatisfactory outcomes when these were investigated internally. These concerns were voiced to managers in Kerelaw to little effect, and escalated and reported to Social Work HQ in Glasgow. Although investigations of allegations in late 1997 did attract follow-up by external management, there was very little evident lasting impact. In August 2002 and in early 2003, the CRO detailed concerns in writing in SWSI questionnaires prior to inspection of the Kerelaw Secure Unit, but there appeared to be no substantive follow-up.

7.8 Those who investigated the 1997 allegations had concerns about aspects of practice and the possibility that staff were covering up for one another. They concluded that a number of practices in Kerelaw Open School needed to be urgently reviewed. A recommendation for disciplinary action was made in respect of one of the care workers concerned, but this was modified with the agreement of the Head of Service to management action by the then acting Principal. The rationale for this was to allow the individual concerned an opportunity to improve practice. The management action was properly followed up some time later by the acting Principal, and formally recorded.

7.9 Complaints and allegations which were investigated were dealt with as they arose and, in keeping with Council disciplinary procedures, warnings were considered “spent” after set periods of time. As a result, even though certain employees were the subject of investigation on more than one occasion, any pattern of past complaints or allegations was not usually taken into account. Although the neighbouring authority’s 1997 complaints had been investigated and followed up by the Head of Service, the Inquiry found little evidence of systematic senior internal or external management monitoring of the frequency of complaints against particular individuals, or of alarm bells ringing as to individuals’ practice. There were some concerns over certain night staff, about whom there had over the years been a number of complaints about heavy-handed treatment of residents, but any action tended to be *ad hoc*.

7.10 Growing concern about night staffing, particularly after a major disturbance (“the Kerelaw riot”) in May 1998, led to a review of night care arrangements. Among other things, this resulted in additional staff cover at night in each unit. This was a positive development, but complaints continued to surface. For example, in September 2001 two girls made allegations against a member of night staff who had previously given cause for concern. A further allegation was made against the same individual in December. However, fact-finding did not take place until the following June, by which time it was difficult to obtain evidence. In July 2004, another night-shift worker was, as noted at paragraph 7.5, convicted of assaulting a female resident, having previously been disciplined.

7.11 Complaints were not restricted to night staff. In 2001, for example, a unit manager was subject to a disciplinary hearing over an allegation of inappropriate restraint and was given management counselling. In January 2003 there was fact-finding into the “aeroplaning” of a boy by five Kerelaw staff. In March 2003, the same unit manager who had been given counselling as a result of the 2001 disciplinary action was again the subject of allegations, as was another member of the unit. This resulted in an investigation which did not end in disciplinary action. However, it was again decided that there should be a management discussion with the unit manager to deal with practice issues. This was led by the external manager, in the presence of the Principal. The manager was then moved and put in charge of the Millerston unit, where complaints in early 2004 about his management style set off a chain reaction of allegations of abuse carried out by a number of staff.

7.12 In the Summer of 2003 there were various complaints from young people of assault by members of staff during restraints, but investigations failed to obtain corroboration. In late October a teacher was investigated for inappropriate restraint, but again there was a lack of corroboration. In the Autumn and Winter a range of allegations by former residents and employees began to emerge. This coincided with clear signs that a number of staff felt under pressure as the proportion of difficult young people admitted to Kerelaw, and those aged over 16, grew. In December 2003 an ex-employee made a formal complaint through SIRCC about an assault on a young woman in which he alleged there had been a cover-up. This was followed up a few days later in an interview with the external manager.

7.13 There was also an issue around staff drinking on night duty over the New Year period. In January 2004 the external manager raised his growing concern over Kerelaw with the Head of Service and the Depute Director, Children and Families and Criminal Justice. With their agreement, he began to prepare a paper setting out those concerns and the basis for them. In February a female employee in Millerston unit alleged bullying by the manager, and made a formal complaint. She was joined by another female employee and an addictions worker, one of whom also alleged abusive behaviour towards a resident.

7.14 A former resident also came forward to allege abuse by a manager in the early 1990s. A former Deputy (Open School) raised concerns about oppression and bullying during the same period. A visiting SVQ assessor complained about the way a care worker spoke to a young person. A fourth female member of staff came forward with information relating to the manager of Millerston unit. In April a care worker in an exit interview with the external manager alleged that a boy in Millerston unit had “received a kicking”.

7.15 Despite the emerging allegations of abuse of residents and the growing concerns of the external manager, the initial response was to begin a fact-finding investigation of the allegations of bullying of staff by the manager of the Millerston unit. This began in April 2004 and was led by two Council officers from the Social Work Department. The unit manager was moved *pro tem* to Centenary House in Glasgow.

7.16 In May, not long after the publication of the report of a Care Commission/HMIE Inspection carried out in November 2003, a former resident of Kerelaw, who had visited the school the previous year, contacted Glasgow City Council alleging abuse by a teacher in 1979. Although the person concerned was shortly afterwards interviewed by two members of Council staff, his allegations were quickly passed to the police, who began the investigation which led to the teacher’s conviction.

The Millerston investigation

7.17 During the fact-finding into the allegations of bullying of staff, employees raised a number of concerns about how young people at Kerelaw were cared for. Some residents then began to speak to the investigators. This was reported to the external manager and the Head of Service, who instructed the fact-finders to carry on with their investigations and consider the young people’s complaints. Young people consistently mentioned 4 staff at this stage and said they had complained in the past. They talked about a “zero tolerance” policy in Millerston Unit associated with an oppressive culture and inappropriate restraints. Staff used the same term to describe the policy. There were also suggestions that some unit staff engaged in a “worst worker” competition and that abusive language was regularly used in references to young people.

7.18 The investigators fairly quickly formed the view that the police should be informed. So far as we can establish, the external management view was that further internal work was needed. The Director of Social Work was not informed at that stage. The internal investigation continued. Having interviewed staff and residents, the 2 investigating officers completed their report in May and sent it to the Head of Service. They continued to argue that the matter should be escalated within the Council and that the police should be informed.

7.19 On 15 June the external manager, drawing on the findings of the Millerston investigation, on his own experience of Kerelaw, and on his interviews with individuals who had come forward to him over a period of several months, made a report to the Directors of Social Work and Education, and senior Department managers. This outlined the findings of the Millerston investigation. It made serious criticisms of local management, and referred to poor relations in Kerelaw’s SMT, cliques and undermining gossip to which these were said to be related, and poor communications between the Secure Unit and Open School.

7.20 His report also noted failures in the response to previous complaints about the unit manager on whom the investigation had initially focused. It referred to a number of flawed disposals in other disciplinary cases, including those related to night-shift workers. The report recommended further investigations, including investigation of senior management failures at Kerelaw. This was agreed, and the Director of Social Work decided that the police had to be involved. A number of staff had already been suspended and further suspensions were to follow, including that of the Principal of Kerelaw, on grounds of management failure.

Establishment of the joint investigation team

7.21 More allegations emerged. In Summer 2004 the Council set up a joint investigation team to consider current and historical allegations of abuse against a number of Kerelaw staff and managers. Initially, the expectation was that the Council investigators would work jointly with the police, and that only a few months would be needed to complete their work. In practice, police and Council investigations ran in parallel, and took significantly longer than a few months. We discuss the investigations in Chapter 15

8. THE NATURE OF ABUSE

Glasgow' City Council's investigations

8.1 The conclusion of Glasgow City Council investigators, as we noted at paragraph 2.2, was that a core of around 40 staff was involved in abuse and a much larger number colluded over a long period of time. The publicity given to this conclusion, and the inferences drawn as to the nature of the abuse, brought a strong reaction from many former Kerelaw managers and staff. Many expressed disbelief and shock, on their own behalf or on behalf of others. Some remain angry about what was reported, expressing disdain for Glasgow City Council and the investigation that continues to be aired in the media and various public forums.

8.2 These strong reactions are not confined to those who were subject to allegations and implicated in abuse. Some who left Kerelaw with an unblemished record consider that they have been branded guilty by association. Others, whose involvement was to place young people in Kerelaw, worry about the extent to which they may have colluded in abuse without knowing. Many who were the subject of unsubstantiated allegations are angry about the Glasgow Report. Others are concerned that the report adversely affects the whole residential child care sector, undermining confidence and casting doubt on the ability of anyone involved to care properly for young people. The Inquiry notes that a significant number of ex-staff who were interviewed told us that they had not read the report at all, some commenting that it was hardly worthwhile, given its short length.

8.3 Some former residents have also expressed concerns about what has been said about Kerelaw. It was home for a time to a great many young people over more than 30 years and some who felt that they had a good experience have been upset by the negative commentary on Kerelaw and the people who worked there. Such commentary has caused concern to families and friends, and to organisations involved with the survivors of abuse.

8.4 Although it was not the Inquiry's remit to consider individual cases, we took the view that we should test the Council's conclusion and look closely at what the abuse was. This revealed a more complex picture than might be inferred from the brief Glasgow Report. The report stated that a range of allegations of abuse resulted in disciplinary proceedings against 23 of 38 staff who were subject to fact-finding investigations. The allegations constituted a substantial list and included physical assault, some of it arising from the inappropriate use of restraint, including pain compliance, sexual misconduct, excessive horseplay, and aggressive behaviour. Investigations were also said to have uncovered examples of emotional abuse in which young people were denigrated and disparaged.

8.5 While the Inquiry was able to confirm from the records we checked that 38 people had been subject to fact-finding, we identified 29 individuals who by the end of 2008 had in fact been disciplined. We are aware that disciplinary action continued after the Glasgow Report was published and this may account for the disparity between the Inquiry's figure of 29 and the Council's figure of 23 at August 2008, although we were unable to confirm this. The disciplinary actions resulted in 14 dismissals and 13 individuals received other disciplinary outcomes, including written warnings and management discussion followed by return to work. Most of those who were dismissed appealed, but only one appeal was upheld by the Council's Appeals sub-committee, with a reduced penalty of a final written warning. Some then went on to Employment Appeals Tribunals which deemed dismissal to be unfair in the case of the Principal and the Deputy Head (Open School). The Council conceded two

Tribunals on procedural grounds. Two have lapsed or been withdrawn by the appellant and three remain active.

8.6 Many who gave evidence to the Inquiry disputed the picture painted by the Glasgow Report and by the media coverage of the Court cases involving the art teacher and the unit manager. Those included supporters of both men, ex-employees, former sessional workers and academics. Some ex-staff accepted that physical abuse may have taken place, but argued that it was not intentional or that it was not regarded as abuse at the time.

Sexual abuse

8.7 Some of the criticism of the Glasgow Report was strongly expressed, notably in relation to the inference that might be drawn that sexual abuse was widespread, systematic and longstanding. Many former staff who gave evidence found it hard to believe that sexual abuse had occurred, but accepted that convictions had been secured. Some with hindsight questioned whether they themselves had been sufficiently observant. There was agreement by witnesses that sexual abuse is by its nature secret and, as a result, difficult to secure sufficient evidence to prosecute; and there was recognition that sexual abuse beyond that which came before the Court in 2006 might have occurred, without their being aware of it. A small number of witnesses were unwilling to accept the verdicts of the Court.

8.8 The Inquiry is not in a position to say whether sexual abuse occurred on a larger scale or over a longer period than established by the convictions of two former employees. The Inquiry was not charged with looking at individual allegations and we did not seek any out. We note that beyond the three ex-employees who went to Court on sexually-related charges, there have been no further prosecutions for sexual abuse at Kerelaw so far. At the time of writing we understand that there are no current police inquiries into allegations of sexual abuse at Kerelaw, although the possibility of further complaints of criminal conduct and police inquiries cannot be ruled out.

8.9 We also note that, although the Glasgow Report refers to sexual, physical and emotional abuse, sexual abuse and misconduct accounted for a small proportion of the allegations made to investigators and followed up by them. This is consistent with research into large-scale abuse in residential settings. According to Barter¹² (2003) writing on the abuse of children in residential care:

Within US research no clear pattern has emerged regarding the type of abuse children in residential facilities most commonly report. Both US research and the limited number of UK studies suggest that sexual abuse is not the most commonly reported form of institutional maltreatment.

8.10 On the other hand, according to Barter:

.....there may exist substantial differences between what abuse occurs and what is reported. Due to the secretive nature of sexual abuse there may be fewer opportunities for external individuals to witness and subsequently to report the incident. Children themselves

¹² Barter, C *Abuse of children in residential care*. NSPCC: 5. (2005)

may be particularly reluctant to report sexual abuse, feeling embarrassed or that they may not be believed.

8.11 While we cannot form a view of the scale of sexual abuse at Kerelaw beyond what has been established in the Court, only 21 cases of alleged abuse of different kinds were referred to the Procurator Fiscal. These included those with a sexual element. It would therefore be very unfortunate if the inference drawn from the broad-brush conclusions in the Glasgow Report and the associated media coverage was that all of the core of staff to which the Report referred were involved in sexual abuse.

Physical abuse

8.12 The question of what constituted physical abuse and how widespread it was is complex. The proposition that there had been physical abuse as suggested by the Glasgow Report was challenged by a number of staff who had been subject to investigation and by others who came forward to the Inquiry. The most robust denial was from some of those who had been disciplined, although there was also recognition that certain practices which had once been acceptable had become unacceptable with the passage of years, as child protection policies and regulation had developed and as societal sensitivities to violence against children and young people had strengthened. Some witnesses – ex-residents and staff alike - seemed able both to deny that abuse took place and at the same time describe practices that were abusive.

8.13 Glasgow City Council's investigators interviewed employees of the school prior to its closure, past employees, former and current residents, parents and associated professionals, and scrutinised a large number of records and logs. The Inquiry received oral evidence from all but one of the 13 people who were at one time or another directly part of the investigation team and accessed written records of their interviews with over 90 young people and 100 staff during their two-year investigation.

8.14 Not all the residents or former residents interviewed by the Council's investigators made allegations. A number said that their experiences at Kerelaw had been positive. Some appeared to accept violence against them as a normal part of their lives or in some cases had concluded that it was justified by reference to their behaviour at the time. Some took the view that the good things offset bad things that happened to them. It was, however, possible from the records of the interviews to build a picture of an institution where - irrespective of whether specific allegations against particular individuals were in all respects substantiated - maintaining staff control over young people had a high priority, and where physical restraint played a significant part in many young people's lives. The Inquiry received evidence from former staff and others which confirmed this picture, and which was described by some witnesses as the result of a legacy of Kerelaw's origins as a List D school. We shall return to this in Chapter 9

8.15 A number of witnesses put it to the Inquiry that, as Kerelaw was required to manage a difficult client group, staff had to be in a position to maintain order, for their own safety as well as that of the young people. We acknowledge that appropriate levels of control are necessary in a volatile environment if staff are to feel safe and secure in the workplace, and if young people are to be protected, sometimes from themselves. This may from time to time require physical intervention. Order is also important if constructive work is to be done with a potentially disruptive client group. But it is neither acceptable nor productive if physical

intervention becomes the first or indeed the “normal” response to actual or potential disruption. Nor is it acceptable if physical intervention is used as punishment, or takes place outside approved procedures, or is disproportionate to the circumstances to which it is a response.

8.16 Evidence from the Council’s investigations and from ex-employees and young people to the Inquiry suggests that for some staff at Kerelaw physical intervention was a first, rather than a last, resort in dealing with difficult behaviours. This appears to have been an approach that became particularly favoured by certain individuals as the client group’s behavioural problems became more challenging. Young people who had been restrained in other residential establishments, and who had experience of how restraint should be carried out, often complained to investigators that on many occasions it was not practised in accordance with the approved procedures. The evidence also suggests that practice could vary from unit to unit and be dependent on which staff were in charge at the time. An ex-teacher put it to the Inquiry that if physical intervention was followed properly:

then it is fine but there were concerns it was being used for swearing for example...it seemed to depend on who your unit manager was...

Therapeutic Crisis Intervention

8.17 Precipitate use of physical restraint in an actual or potential incident would have been inconsistent with the policy of “Therapeutic Crisis Intervention” introduced by Strathclyde Regional Council in 1995 and adopted by Glasgow City Council after local government reorganisation. Skinner (1992) saw training in conflict avoidance and managing violent behaviour as essential for residential care workers. He observed that for children to feel safe in care there needed to be clearly set limits to acceptable behaviour. Physical restraint remains a controversial area and one which many children complain about. National guidelines *Holding Safely*¹³ were finally published in 2005, and a number of different methods of managing challenging behaviour, including restraint, are used throughout Scotland.

8.18 TCI is a system for preventing and managing challenging behaviour in young people. Although it provides for physical restraint to be employed and sets out guidance on how this should be done, it is in fact a system intended to reduce the use of restraint. The system was developed by Cornell University in Ithaca, New York in the early 1980s, following research that indicated young people and staff were being injured through the use of restraint in residential facilities. This was seen as a consequence of restraint being used too readily and of an absence of training in safe methods. TCI was introduced in the UK in 1993 and is now used by around 70 agencies.

8.19 All staff at Kerelaw were required to undertake training in TCI and a programme to enable them to do so was introduced in the mid-1990s. Records confirm that staff did undertake training although, as this required a minimum of 4 days away from post, finding time could be difficult. The current version of TCI, which dates from 2001 and is being revised, stipulates that refresher training should take place every 3 to 6 months, a significant

¹³ *Holding Safely: A guide for residential child care practitioners and managers about physically restraining children and young people.* The Scottish Executive, SWIA, SIRCC (2005)

resource commitment. In the 1990s the frequency of refresher training was advisory, rather than compulsory, and at Kerelaw it fell behind badly.

8.20 The TCI student workbook is a substantial document. Some two thirds of it is devoted to management techniques aimed at stopping escalating behaviours and helping the young person regain control, with the intention of avoiding physical restraint if at all possible. Training must be carried out by certified trainers and must cover the full system, not simply the physical restraint elements. The strong emphasis on TCI as a “system” is important, and its designers recommended that senior management receive training as well as operational staff so that it is supported by appropriate leadership, supervision and monitoring.

8.21 The introductory pages of the workbook describe TCI as a crisis prevention and intervention model for residential child care facilities which assists organisations in preventing crises from occurring, de-escalating potential crises, managing acute physical behaviour, reducing potential and actual injury of children and staff, and teaching young people adaptive coping skills. TCI recognises that physical restraint may be necessary in the interests of safety, but notes that the physical techniques presented in the training should never be seen as an end in themselves.

8.22 The workbook spells out very clearly what physical intervention does not do, in the following terms:

It is not used for retaliation, discipline, or punishment. It does not intentionally inflict pain, injury or harm to the young person. It is not physical abuse. Techniques such as hitting, yanking, or pushing are not applications of physical restraint.

8.23 We were told in evidence that most staff broadly welcomed the training in TCI. Prior to the introduction of TCI many staff had little or no training at all in safe physical interventions, and were expected simply to handle crises as best they could. Some staff had undergone training in the 1980s and 1990s at Gartnavel hospital in physical restraint involving pain control techniques, more akin to that used by the prison services and secure psychiatric hospitals. Many staff were uncomfortable with that. For them TCI was a welcome development, and we heard evidence that there were examples of good practice in TCI at Kerelaw.

8.24 For others it was a less welcome development, with some unconvinced as to its suitability for use across the board. Some appear to have misunderstood that TCI was a systemic approach to reducing the need for physical intervention, seeing much of the instruction in de-escalation as the “theory”, and restraint as the practice. Others appear to have been more overtly hostile. We were told by one ex-staff member that some staff:

had a less mature attitude to the use of restraint and the impact on young people. At training many showed a dissent to learn and presented a dismissive attitude by reading the newspaper and asking when the training would finish. Some would get up and walk out or skip parts that they did not like.

8.25 This should have been picked up both by trainers and management and followed up. There is evidence that for some staff shaking off the legacy of training in pre-TCI pain-compliant methods was difficult. It was put to the Inquiry by one observer that:

Staff had been trained in painful holds. Then they were taught TCI and told not to use the old method. A lot of staff struggled with TCI.....

and by a practitioner that:

the aftermath of the Gartnavel training was still present in how staff behaved..... people went too quickly to the last stage.

8.26 That some staff struggled to grasp the point of TCI is not surprising when one considers this extract under the heading “Discipline/Care Control” from a Kerelaw School and Secure Unit document in 1997:

On occasions young people in secure lose all personal controls and act out in an extremely violent fashion. In order to maintain the safety of themselves and others measures of restraint have to be used. A number of staff have been trained to cope with these incidents, and by June 1996 all staff had completed this training. The social work department has endorsed this training which is the programme of behavioural management approaches and techniques known as Therapeutic Crisis Intervention.

8.27 An ex-Kerelaw employee, reflecting frankly to the Inquiry on his own practice, admitted that there were many inappropriate restraints and that he quickly became part of the culture and took part. His view was that at Kerelaw:

they talked about TCI as a restraint technique rather than as a wider method. At Kerelaw there had not been an emphasis on TCI as a way of avoiding restraint... When restraint did occur people ended up reverting to old techniques.

8.28 This explains the emphasis laid by the developers of TCI on leadership by management, supervision, monitoring, and refresher training. However, there is a debate to be had as to whether de-escalation would be effective in all circumstances, particularly where the safety of a young person or persons, or staff members, was at immediate risk. If harm, including self-harm, is imminent, there may be very little time to de-escalate, and no alternative to a quick, but proportionate, physical response. The Inquiry saw reports of violent incidents, which provide a vivid picture of the kind of behaviours and aggression which staff often had to manage. One former staff member summed up his difficulty. He did not consider that:

TCI assists you to stop a young person going for another young person with pool balls in a sock, for example.....nothing teaches you how to intervene to stop this happening and if necessary restrain the child.

8.29 There were occasions when de-escalation techniques provided for in TCI were used successfully at Kerelaw, and we heard witnesses refer to them. There were also occasions

when proportionate, physical intervention to prevent harm was employed by staff at Kerelaw in a professional manner, with best intentions. This was confirmed by a number of young people. However, the volume of concern raised by residents and former residents with Council investigators about the way in which restraint was used and carried out by certain members of staff at Kerelaw, and the consistency of their statements across successive “intakes”, do lead to the conclusion that many restraints involved painful holds and inappropriate locations or surfaces. Some of those restraints resulted in injuries to residents, including bruises, carpet burns, and in at least one case damage to a limb, and did not reflect observance of TCI. Some resulted in injuries to staff as well. One young woman summed up her experience of restraint at Kerelaw in the following terms:

[she] was restrained a lot of times by various staff but did not think usually it was done the way it should be done – they pushed her face in the carpet, pulled her arms back, put their knees into her back to keep pulling her legs up..... it felt like they were pulling her body apart. This could happen if somebody was in a bad mood – she just had to say the wrong word and they would restrain her.

8.30 Disturbing though that description is, it does not mean that in all cases of inappropriate restraint the staff involved set out to cause injury to a young person. As noted earlier, TCI requires staff regularly to refresh their training, in all aspects of the system. They are also supposed to be re-tested annually, although the Inquiry was told that prior to 2001 it was only the physical part that was tested. While new Kerelaw staff would receive TCI training, there is ample evidence from the Glasgow City Council investigations, from North Ayrshire Council inspection reports and from paperwork seen by the Inquiry that staff did not receive refresher training or testing as they should have.

8.31 In May 2000, following analysis of Violent Incident report forms, the Head of Service raised in writing with the then Principal the question of TCI refresher training for Kerelaw staff. In the Autumn of 2000, a North Ayrshire Council Inspection Report on the Open School concluded that TCI refresher training needed to be developed. In early 2001, North Ayrshire Council reported on an inspection of the Secure Unit and noted that TCI refresher training was an issue there, as it was in the Open School, and that this training had “slipped”. A year later, in its February 2002 report of a follow-up inspection of the Secure Unit, North Ayrshire Council again noted that TCI refresher training was overdue. In May 2003 the Principal issued a policy statement on TCI to staff, but it appears that it was not until after more robust external management arrangements put in place over the Summer of 2003 had identified a range of shortcomings in the use of restraint, poor recording practice, and inconsistent responses to incidents, that attention finally turned to TCI refresher training.

8.32 In the absence of regular refresher training, staff may well have lost sight of the main purpose of TCI, which was to reduce the need for physical restraint, even if they had clearly understood that in the first place. Nor would knowledge have been updated. For example, the Inquiry learned that there may have been confusion over whether TCI sanctioned the physical removal of a young person who was being disruptive to another place. Techniques for staff physically to “remove” or “escort” a young person were taken out of the 2001 version. While their intention had been to permit small movements within a given space, some practitioners saw this as licence to remove a young person from, for example, a communal area to a bedroom, where actual restraint might then be carried out. A common allegation by young

people was that they were often manhandled or dragged upstairs to their rooms where “TCI” – or, more accurately, physical restraint – was then applied.

8.33 We saw a written assessment in the files of what was required so far as TCI training was concerned:

The 1-day refresher course run at Kerelaw is inadequate to update staff who were trained over a year ago (some staff did the course as far back as 1995/96). The TCI System has been considerably updated and amended in recent years and it is important that staff are fully refamiliarised with this. During refresher training some staff are still referring to outdated TCI books and holds which are no longer used..... the two day refresher course designed for use in GCC SWS Units should be used for all future updates done annually.....More attention should be given to ensure that the TCI System is integrated into general practice, particularly de-escalation techniques, behavioural management approaches and appropriate use of the LSI [Life Space Interview]. TCI is a broad-based system for general practice in residential child care and needs to be integrated into the wider management of and operations at Kerelaw.

8.34 The assessment, dated 2003, included a query as to whether teachers needed to be “refreshed” as well. It appears that they did, and it was decided that all education staff should be called in for retraining. This required approval from education managers in HQ to close the school for a week. The training was described to the Inquiry by one manager at Kerelaw as a “disaster”, with many managers and staff failing to attend at all or with attendance subsequently tailing off. The trainers were internal to Kerelaw, but were said to have stopped the training on occasion because of problematic conduct by participants. The Inquiry was told that the legacy of the event was the emergence of increasingly divisive practices, with teaching staff unwilling to implement TCI, instead preferring to call the police.

Intentional harm

8.35 Without proper refresher training and testing, any confusion in the minds of staff as to what was and was not acceptable under TCI would not have been addressed. Similarly, and despite what we heard about the attitudes of certain employees, some physical interventions by staff which they thought were TCI-compliant may have been carried out clumsily, thus resulting in pain and injury, but without an intention to harm. In her directions to the jury at the trial of the teacher and the unit manager, the trial judge, Lady Paton, sought to clarify the importance of intentional harm in determining whether a non-sexual assault had taken place. She suggested among other things that if a restraint was imposed for “cheek” or a “bad attitude” then it was imposed with “evil intent”. (“Evil intent” is the intention necessary for assault.)

8.36 Some staff against whom allegations of physical abuse were made successfully argued to investigators or at disciplinary hearings that there was no intention to harm (ie “evil intent”) in their actions at the time, and this was repeated in evidence to the Inquiry. This defence was prayed in aid not only in response to allegations of heavy-handed physical restraints but also in relation to what some former employees and Unison have described as “horseplay”.

8.37 “Horseplay” is easier to recognise than to define, but might be described as rough and tumble, perhaps including “play fights”, arm-wrestling, prodding, tickling, and other apparently non-threatening, light-hearted physical contact. This may be a commonplace in many ordinary private households. Where horseplay involves adults interacting with young people in residential care, its defenders may argue that it can have a beneficial effect in terms of relationships and trust, and that it simply reflects interactions which take place in stable and nurturing family settings. The opposing view is that it reinforces the unequal relationship between adults and children and in a residential setting provides adults with a means to demonstrate power and control, which can be abusive, and which in certain circumstances might also provide cover for inappropriate sexual contact. Horseplay may well conceal an intention to harm.

8.38 In an October 2007 paper responding to Glasgow City Council’s conclusions about Kerelaw, Unison argued that horseplay was an issue on which staff were judged by standards that had changed and were different in 2005-6 from what had been acceptable years before. There may be some basis for that view so far as the period prior to that covered by the Inquiry is concerned. However, although horseplay might in the past have been accepted in residential settings, that had ceased to be the case by the mid-1990s. The Council’s *Care and Control Policy* for residential establishments, which was re-issued in March 1998, was explicit that staff must not engage in horseplay. Moreover, a number of young people complained to investigators of physical contact from some staff members which, although disguised as “horseplay”, went beyond what would at any time have been considered acceptable.

8.39 The most benign assessment of inappropriate behaviours at Kerelaw during the period covered by the Inquiry is that a number of staff were responsible for poor practice, either through what they regarded as horseplay or in the way in which they applied physical restraint. This poor practice then either went unremarked or was not sufficiently challenged by colleagues or managers. In either interaction there may or may not have been an intention to harm, but even if there were not, poor practice should have been challenged and addressed: the absence of intention to harm does not make poor practice acceptable.

8.40 It was suggested to the Inquiry that, as the Procurator Fiscal decided to prosecute for physical assault in only 2 of the 20 cases put to him by the police as a result of Operation Chalk, there was no intention to harm and that therefore physical abuse was exaggerated in the Glasgow Report. It is neither possible nor appropriate for the Inquiry to comment on decisions of the Procurator Fiscal, or on the specifics of the cases put before him. The allegations reported to the Procurator Fiscal were thoroughly investigated, before being reported to Crown Counsel who considered the full facts and circumstances of each individual case before making a decision. Before any decision to prosecute could be taken, Crown Counsel had to be satisfied that there was sufficient admissible, credible and reliable evidence to prosecute. There requires to be corroborated evidence to establish that a crime has been committed and to prove the identity of the perpetrator. That is a much higher standard than that of the balance of probabilities test which would apply in consideration of a child protection intervention or in the context of disciplinary action against an employee.

8.41 It is against the latter test that Glasgow City Council drew the conclusions that it did and proceeded with disciplinary action against particular individuals. From the employer’s point of view, intention to harm would not have had to be established to proceed with a disciplinary hearing, although it might have had a bearing on the outcome and on the

disposal. Non-compliance with Council policy could be a disciplinary matter, and a number of young people, again drawn from different age groups who were not at Kerelaw at the same time, complained to investigators that physical restraints took place that did not comply with approved guidelines. They also alleged that restraint was used by some staff as a first rather than a last resort, and that it was often used to deal with “cheek” or “bad attitude”. A young woman’s experience of this in the late 1990s was recorded in the following terms:

If there was one thing that should have changed it was the way restraint was done at Kerelaw. Restraint was used too quickly, sometimes just for swearing...it wasn't done properly. They would deck you too quickly. They used to put your arms up your back. It was also common for staff to say horrible things to you while you were being restrained.....this included references to[her] adoptive parents and how they would not want [her]back. There was always someone being restrained.

8.42 That restraint was not confined to dealing with physical aggression, or employed as a last resort in compliance with TCI, was confirmed by some former staff members, for example in relation to the “zero tolerance” policy in the Millerston Unit. That being so, if Lady Paton’s test is taken as a guide, the actions of some staff were on occasion consistent with an intention to harm.

8.43 A more troubling assessment of what took place at Kerelaw is that there was a complex set of behaviours and motivations. These ranged from poor practice, a lack of compliance with TCI and the clumsy application of approved restraint procedures, to physical handling and treatment which were outside the scope of the approved procedures, and which in many cases amounted, on the balance of probabilities, to deliberate assault. Evidence available to the Inquiry does not lead us to conclude that it would be right to interpret the Glasgow Report as saying that a core of 40 people came daily into work at Kerelaw determined to inflict pain and punishment on young people. Some may have been very willing to do so, some may have resorted to doing so under pressure, and some may have been sucked into a culture in which showing who was the boss was important. Others may have inflicted pain through misunderstanding or misapplication of procedures. To some extent that complexity was recognised in the range of outcomes for individuals following the investigations and the subsequent disciplinary action, where that took place. But whatever the motivations, we believe that physical abuse did occur at Kerelaw, a significant core of staff was involved, and a number of others did not challenge it as they should have.

Emotional abuse

8.44 All forms of abuse carry an element of emotional abuse, the more so if the abuser is in a position of trust. Throughout our evidence-taking we heard from ex-employees and others that Kerelaw was treated as a “dumping ground” for particularly difficult children who had “failed” in other residential placements and for whom Kerelaw was the “end of the line”. As we note at paragraph 12.24, Kerelaw was indeed the destination of last resort for many difficult, disruptive and damaged young people whose placements elsewhere had not been successful, and the records of incident reports illustrate well the challenge many of them posed.

8.45 However, that does not excuse poor treatment or abuse. The language of failure and dumping, though never far from the surface, seemed to gain increasing currency among some managers and staff as the proportion of children from Glasgow rose, as the numbers of those aged 16 and over, and problems associated with drugs, grew. A paper entitled “Improving Services to Young People” prepared by the Principal in June 2004 acknowledged that:

certain members of staff had developed negative attitudes to young people

and that recent events – a reference presumably to the Millerston investigation:

*had highlighted the difficulties associated with keeping young people safe...
when there is not an ethos and culture that values and respects young people*

8.46 The negative attitudes and culture were not conducive to the creation of the caring therapeutic environment to which Kerelaw’s plans and statements of purpose referred. The paper said that there was a need to ensure that all staff worked with young people through building relationships that respected and valued them as individuals. Had this been more fully recognised, communicated and embraced by all staff, more young people’s experience of Kerelaw would have been positive; so too the experience of more staff.

8.47 A number of former employees told Glasgow City Council’s internal investigators that certain employees referred to residents in very disparaging terms. The Inquiry was also told, by other sources, that it was common for young people to have their troubled histories used against them by staff who should have been working to enable them to move forward with their lives. One external advocate for young people’s rights told the Inquiry that in her opinion Kerelaw staff were fairly consistent in the approach that they were dealing with “bad” children, and not children with challenging behaviour as a result of difficult or abusive family backgrounds. She stated that these attitudes were displayed openly in front of young people and other professionals. Another witness to the Inquiry was clear that:

*negative attitudes to the young people at Kerelaw were held by both
those staff working at Kerelaw and other staff.....the attitude
to young people at Kerelaw was terrible.*

8.48 A frequently quoted example was of young people being discouraged from complaining by being told that because of their past they would not be believed. It was put to us that staff undermined the complaints and testimony of young people by referring to their personal histories and reasons for being in care. A witness to the Inquiry who pursued a complaint on behalf of a particular individual heard a staff member undermining the testimony of a young person on the grounds that he had “said his stepfather hit him all the time and they never proved that either”.

Conclusion

8.49 The Inquiry believes that physical and emotional abuse of young people took place at Kerelaw over a period and was associated mainly with a particular core of staff. Although this was a concern for some of their colleagues, it went largely unchecked. Not all staff engaged in abuse and those who physically abused young people will not have done so all the time. Some may not have believed that what they were doing was abuse. Nevertheless, it was abusive and should not have occurred.

9. ORGANISATIONAL CULTURE

9.1 The changes in legislation and policy in residential child care in the 1990s required staff to gain new knowledge and adopt new approaches to working with the children in their care. That Kerelaw might benefit from a fresh approach appears to have been recognised by Strathclyde Region in the form of at least one appointment to the senior management team in the early 1990s. However, we heard in evidence that, under Strathclyde Region, Kerelaw was seen as somewhat separate from the mainstream, and that some managers and staff had developed a resistance to being told what to do by “outsiders”. As a consequence, there appears to have been a culture which made Kerelaw less well placed than it might have been to adapt to new legislative and policy requirements.

9.2 An organisation’s culture may be simply described as “the way we do things around here”. Management text books abound with more detailed definitions, but Osborne and Brown (2005)¹⁴ capture the essence:

The shared ideas, customs, assumptions, expectations, traditions, values and understandings that determine the way employees will behave

Culture is a product among other things of history, role, attitudes of managers and staff, and their perception of their purpose and self-worth. In the public service, dealing as it often must with some of the most challenging and marginalised client groups, the attitudes of the public to the client group may also influence culture.

9.3 The public can be ambivalent about the kind of challenging client group with whom staff at institutions like Kerelaw have to work. A view that tough discipline and “just deserts” may be appropriate for the most challenging young people may coexist with disapproval of abusive behaviour towards the vulnerable. This ambivalence, sometimes reflected in Government policies and the media, may transfer to some staff and lead to their being confused as to what is expected of them. Some may believe that poor treatment of the client group is excusable, at least from time to time, because the public either considers such treatment to be justified or does not care. Some may think they are doing the right thing when they are in fact doing the wrong thing.

9.4 If staff are unsupported or otherwise undervalued by their employer, for example by being inadequately resourced or trained for the job they do, by seldom seeing senior management, or by having to work in poor surroundings, they may feel isolated and vulnerable. Use of the employer’s disciplinary process as a first response to practice issues may increase feelings of vulnerability, to which negative media coverage may add. A feeling that they are themselves subject to a “blame culture” may influence staff behaviours towards clients. At the same time it may nourish the development of an inward-looking, defensive ethos in which loyalty to one’s colleagues, or at least to those perceived as being on one’s side, takes precedence over other obligations. Solidarity with one another in difficult circumstances may be reinforced where large numbers of staff are recruited from, and live, in the local community, and where there is shift work and shift-based socialisation outside working hours.

¹⁴ Osborne, S P and Brown, K *Managing Change and Innovation in Public Service Organisations* (2005) Routledge

9.5 A strong value base is needed to counter negative cultural influences of that kind. Strong leadership, training, supervision and support, and self-evaluation, are key factors in sustaining values, challenging poor practice and creating a culture in which the client's needs are the top priority. In a residential setting for young people, the fundamental requirement is for all workers to embrace a child-centred approach, in which children are listened to, their needs respected and their vulnerabilities understood.

9.6 The concept of the child at the centre is discussed in Chapter 12. Putting this concept into practice when the child is challenging and vulnerable demands a high level of professionalism, skill, and self-control from managers and staff. It depends heavily on role-modelling and standard-setting from the top. It demands from senior managers a shared vision of what kind of organisation they wish it to be, which goes beyond a simple statement of the mission. It requires communication to staff about values and standards, and clarity about what is expected of them. It requires a willingness to question accepted customs and practice and to hold to account those who fall short. It requires a commitment to learning and development to enable workers to adapt to new demands, and respond to changing client needs.

The Kerelaw culture

9.7 There were deficiencies in all the above areas at Kerelaw and negative cultural influences of the kind described. Nevertheless, there were many positive aspects to Kerelaw. There were staff who were child-centred, who had a strong value base, and who did their best in often difficult circumstances. By no means all young people at Kerelaw had a bad experience. Glasgow City Council's own investigations recorded a number of positive comments from young people, for example:

I do not have a bad thing to say about my time in Kerelaw, and not a bad word to say about my staff. I felt they had respect for me.

and so far as one young man was concerned:

in terms of his experience of Kerelaw.....he enjoyed it as he was taken to places he would never have been..... "I was treated fairly and we had something to do every night. My two keyworkers ...were very good....."

9.8 This was echoed by another male former resident who:

...went on to say that if you were unhappy you knew who you could talk to and who you couldn't. Some staff were good at noticing when someone was about to erupt and would try and help....[his] key worker.....was good at this.

while a young woman ex resident commented that she:

.....felt that some of the staff had looked after them well, some of them were good and could put up with a lot.

9.9 It is right therefore to acknowledge that there were good practitioners at Kerelaw. We heard in evidence that unfortunately some of them did not stay long or, if they did, felt that they would be unable to bring about change. Either way, the exemplary practitioners appear to have been insufficiently numerous or insufficiently influential to make a lasting impact on a culture which, the evidence suggests, laid a very strong emphasis on physical control, and on supporting one's colleagues when this led to complaints or fact-findings. The evidence given to the Inquiry suggests that the description in the Glasgow Report of:

an insular, staff-centred, controlling culture, where young people were not heard or empowered in any meaningful or effective way, made for an environment in which abuse could occur

is a fair commentary on a culture largely driven by the attitudes and behaviours of a core of male employees, who became the main focus of investigations.

9.10 Those behaviours appear to have been replicated to an extent in behaviours towards colleagues who dissented from the cultural norm. We have already recorded at paragraph 7.15 that what sparked off the Millerston investigation in April 2004 was staff complaining of bullying and harassment by a unit manager. This was despite the fact that a report following a Review of Night Care (see paragraphs 10.15-10.16) had recorded 5 years earlier, in March 1999, in a section headed "Culture":

Almost every member of staff interviewed, permanent or temporary, cited examples of bullying/harassment by management. Staff appear to have been disempowered to the extent that they have been unable to challenge practice. This requires attention, particularly given the need to safeguard very vulnerable and damaged young people. Additionally, staff in efforts to protect themselves, have formed powerful sub-groups, which do not enhance an inclusive working culture.

9.11 That Review went on to recommend that the SMT should work with members of staff to promote an inclusive, supportive way of working which positively encouraged the challenging of concerning practice. These findings were taken on board by the then Principal and a paper setting out a basis from which to take work forward was prepared, but we found no evidence that this was adequately followed through in the longer term. Proposed improvements in the formality and frequency of supervision, which would have been a key tool in changing the culture, were not fully implemented.

9.12 Despite the reasonable gender balance in staffing noted at paragraph 4.24, a consistent message from ex-employees and others who gave evidence to the Inquiry was that there was a "macho" culture, into which many new members of staff appear to have been absorbed. Time and again the Inquiry heard from former employees of the strong impression this culture made on them when they were first recruited to Kerelaw. One former member of staff's evidence to the Inquiry echoed that of several others:

Kerelaw was male dominated and a bit macho when she arrived.....The Kerelaw culture had a macho element and many male staff were not used to building relationships and discussing differences of opinion with young people

while a former teacher told us that:

.....there was a macho culture due to the staff being largely manual workers recruited locally, who did not hold social work values...

9.13 Another former staff member reflected on the staff group he worked with and said that:

there were a lot of 'big guys' employed at Kerelaw and this had been part of the culture..... perhaps being big and strong was seen as more of a priority than having the capacity to write a good report. Staff nicknames reflected this priority

9.14 A young person, resident at Kerelaw in 2002, told the Council's investigation team that:

...a lot of staff walked about like hard men in a way which was designed to intimidate the residents...

but a former manager went further, arguing that:

.....there was no ethical leadership at Kerelaw and it was managers who were influential in maintaining the macho culture.....[but] some staff did realise that things were wrong.

9.15 The Glasgow Report stated that:

Historically, as recently as 25 years ago, it would have been common and acceptable for these young people to be dealt with by means of strict, institutional regimes, characterised by control measures and staffed by predominantly male workers. Young, physically fit males would have been actively recruited as being "hard" enough to deal with the young people in their care.

9.16 Kerelaw's origins as a List D school were cited to the Inquiry several times in evidence. One long-serving staff member observed that:

..... there were issues of culture at Kerelaw where they were trying 'to shoehorn child care practice into a former list D school'

and a professional worker closely involved with Kerelaw over a long period summed up the culture in his oral evidence as:

a macho male dominated culture at Kerelaw particularly in the early days ... the ex-mining, agricultural Ayrshire environment placed an emphasis on 'brawn is best' in relation to list D provision, especially for teenage boys,...

although he also suggested that:

...by 1997management were trying to rid themselves of such cultural baggage and ethos. There was interest in training in child protection and..... many staff, especially female managers, were aspiring to improve.

9.17 We were told that the Deputy Head in charge of the Open School at the time of its transfer to Glasgow City Council in 1996 had been appointed in 1993 in an attempt to bring about change. Her aspirations to improve and introduce practices which ran counter to the prevailing culture encountered resistance from some senior management colleagues as well as staff. Opinion among those with whom she worked was mixed. We heard praise for her contribution to introducing training for staff alongside criticism of how she went about things, even from some who supported what she wanted to achieve. She left Kerelaw in early 1999 and resigned from Glasgow City Council the following year, having failed to gain the support needed to bring about lasting change. A common criticism made to the Inquiry was that she “gave the young people too much”, itself a comment on prevailing attitudes and culture.

9.18 One former member of staff, referring to the Deputy’s attempts to change the culture, noted that:

There was a longstanding control and discipline approach hanging over from Kerelaw’s origins as a List D school and the therapeutic approach that [she] was trying to introduce was just alien to them.

9.19 A former female member of staff told the Inquiry that:

In general staff were starting from a pretty basic level in terms of values.....[she] remembered talking to HMIE about the basic fundamental issues over staff values. They agreed with her. There had been training but this had not been in basic values.....This was a school in the middle of nowhere and the staff had questionable basic values.....an institution with dated practices relating to having been an old list D school

and one witness who had been involved in inspecting Kerelaw told us that:

the attitude that came across from staff was that they ‘policed the children rather than looked after them’.

9.20 A female former staff member remarked that:

Kerelaw had existed before the Regulation of Care, the Children’s Act, and concepts of corporate parenting and so on. But it was a time when organisations and the sector generally were beginning to realise the need to improve the quality of residential care.

9.21 Kerelaw was affected by developments in regulation and needed to improve the quality of care, but we did not in the course of our Inquiry identify a sustained, strong commitment to respond which was shared by the Kerelaw SMT or in Glasgow City Council’s

Social Work Department. With few exceptions, which we return to in Chapter 10, there was little evidence of a vision of what a different future might be and no overt recognition of a need for a modernisation programme which addressed culture change.

9.22 While we saw evidence of concerns being expressed from time to time in the Social Work Department, we found no evidence there of will or capacity to carry out a root and branch review, or to grasp nettles that needed to be grasped. The fact that plans were slowly being formulated for the redevelopment of Kerelaw, initially on the hypothesis of a new site closer to Glasgow, may have been a factor in this. However, we found no documentary evidence that planning in Social Work HQ included consideration of how to take forward a culture change agenda.

Recruitment

9.23 A recurrent theme during the Inquiry was the extent to which Kerelaw recruited from the local community. As the Glasgow Report recorded, many relatives worked together at the school, as did couples and longstanding personal friends. The Inquiry noted the existence of a range of longstanding animosities too. The local networks and personal connections associated with these relationships and the cliquishness were cited as reasons why people did not speak up about questionable practices, and why fact-finding investigators expressed concerns that staff were covering for one another. A member of the Personnel function involved with Kerelaw summarised the problem in the following terms:

Kerelaw was a minefield of friendships and relationships that was not conducive to whistle blowing.

9.24 A reliance on local recruitment is not unusual in residential settings, particularly those located at some distance from large settlements. Working patterns and the cost and time involved in travelling tend to militate against recruiting from the labour pools in the Central Belt to the Ayrshire coast. The workforce at Kerelaw was therefore heavily weighted towards the local communities in the Stevenston, Saltcoats, Ardrossan and West Kilbride areas.

9.25 The situation immediately after local government reorganisation did not lend itself to the recruitment of a settled workforce. A freeze on permanent contracts for care workers meant that it was difficult to retain staff, and covering posts was a continual challenge. Kerelaw was accustomed to carrying out its own recruitment, and not all those who found themselves working there did so out of a strong wish to work with vulnerable children and young people. A regular pattern was that people would become involved as sessional workers, would then get a temporary post and later, after the initial freeze on posts was eased, become permanent. It was not until February 1998 that the acting Principal was able to confirm to his managers that Kerelaw could be exempt from the Council policy of not filling vacancies, thus enabling the school to consolidate a number of temporary posts.

9.26 A month later the Principal recorded in a memo to the Depute Director of Social Work that 30% of staff were on temporary contracts. Contractual problems continued. North Ayrshire Council noted in its February 2000 report on an inspection of the Open School in October 1999 that staff still did not have contracts of employment and that the Council needed to address this as a matter of urgency. This was resolved in the course of the year, with North Ayrshire Council's inspection in October 2000 noting that job descriptions were now available for all grades of staff and that they now had employment contracts – some 4

years after local government reorganisation. Given that experience, it would be understandable if employees felt undervalued by Glasgow City Council.

9.27 Until 2001 there seems to have been little attention paid in Glasgow to personnel practices at Kerelaw. Nobody from HQ Personnel had been involved in recruitment exercises before then. When recruitment took place, Kerelaw appears to have provided little or no information to HQ about who was involved or the process used. Kerelaw was inconsistent with the rest of Glasgow in recruiting to sessional positions also. Practice elsewhere in Glasgow City Council was that there were no sessional posts, only temporary posts and permanent posts. At Kerelaw there appear to have been no clear-cut standards or process for moving from one kind of contract to the other.

9.28 In 2001 the Scottish Executive issued guidance in a *Toolkit for Safer Recruitment Practice* which identified 18 factors for safer recruitment practice, introduced 9 “key capabilities” for the role of residential child care officer and advocated the use of assessment centres for recruitment. Steps were taken to tighten up on recruitment practice across the residential sector and to align Kerelaw with Glasgow City Council’s arrangements. Under the new procedures it was decided that Personnel in Glasgow had to be involved. The Inquiry learned that subsequently the outcome of an assessment centre for residential workers at Kerelaw to make permanent appointments was that some long-serving temporary staff failed, mainly because of their attitudes and values which became evident in a group exercise. However, the staff concerned had apparently acquired employment rights as a consequence of their duration of service and releasing them would have had financial implications. Thus, we were told, they were offered instead further 13 week contracts, after which they sat and passed another assessment centre.

9.29 The Inquiry was told by ex-Kerelaw managers and staff that they constantly struggled to attract and retain staff. We were unable to obtain from Glasgow City Council sufficient accessible data on staffing to examine this in detail over the whole period. However, we were able to consider information about the staff establishment for 2000-01 and proposals put to the Council’s Social Work Resources Committee of 31 July 2001 (see paragraph 13.9) for an increase in staffing, prompted by inspectors’ concerns and by expected Care Commission standards for staffing levels across the residential child care sector.

9.30 Budget figures prepared for 2001-02 show that, of a staff establishment of 109 (excluding teaching staff), there were 16 posts (15%) being covered on a temporary basis – an improvement on 1998 - as a result of long-term sick leave (12), maternity leave (2) and 2 staff away studying for their Diploma in Social Work (Dip SW). The budget figures also set out the costs of proposed administrative and support staff changes that were put to the committee. Other proposals, in respect of residential care staffing, sought an overall increase in staffing of 20 (18%), including consolidation of 7 posts filled on a temporary basis. The paper noted a heavy dependence on the overtime budget, which was 50% overspent.

9.31 This snapshot of Kerelaw’s staffing concerns paints a picture of considerable pressure and potential risk. Posts left unfilled by long term sickness alone amounted to 11% and no account was taken of the need to cover for short term absence for training or other reasons. A number of gaps were filled by staff on temporary promotion, which may bring benefits in terms of development but has a downside if too many managers lack experience.

Relationships and behaviour

9.32 We have already referred to close personal relationships among staff and the existence of cliques and factions. The Inquiry was told this in interviews and also picked it up from the way evidence was presented. Divisions among staff were not only personal. They extended to disagreements over practice, over whether programmes were a good idea or not, over training, and over the value of supervision. To the Inquiry, Kerelaw emerged as an unhealthily factionalised institution, afflicted by divisions within units, between units, between open and secure provision, between night staff and day staff, within the Kerelaw SMT, and between Glasgow City Council HQ and Kerelaw. As we shall see from our discussion of external management in Chapter 13, there were also divisions in the Social Work Department in Glasgow.

9.33 We noted earlier in this Chapter evidence from former employees which pointed to a “macho” culture. We were told that a core of staff who had worked at the school for some time set the tone as Kerelaw moved from its list D status. We understand those workers were close personally and appear to have shared a professional ethos based first and foremost on control. At that stage residential workers were generally not well trained and we were told of a “turnkey” and “brother officer” mentality. The language of “decking” was heard on more than one occasion by the Inquiry, from both former staff and residents. We were told that a small number of staff had established in the Secure Unit at Kerelaw what some saw as an influential, overly controlling and authoritarian regime.

9.34 In 1993 the new Deputy Head (Open School) tried to instigate change in the regime, and we describe at paragraphs 10.3-10.6 some of the tension this created. We were told that a small core of staff struggled to come to terms with a new, more child-centred ethos and actively sought to undermine change. More women were employed and there was an emphasis on care arrangements and associated staff training. The implications of these changes and the fall-out for staff and managers is significant. A divided management team was evident from the mid-1990s and a significant energy and resources were employed in disputes and conflict between key members. We shall return to this in Chapter 10.

Gender issues

9.35 Women were increasingly employed in both managerial and care positions at Kerelaw from the mid-1990s. This coincided with attempts to move towards more care-oriented, relationship-based and resolution-focused practices. Many former staff members we spoke to, including a number of men, welcomed this development. We noted attempts to challenge prevailing norms and practices by particular female staff, although by no means all. Certain gender stereotypes appear to have continued into the later years of Kerelaw’s existence and it was difficult for women to challenge established norms. Those who did not fit in appear to have been marginalised. We were told that one female worker was referred to pejoratively as a “child crusader” for trying, on the face of it, to be child-focused. One male staff member commented that:

...females really had to shine to be noticed – they really had to be very “in your face” to get on. It was almost a given that the female staff would get the messages and would do the primary care stuff – washing and ironing.

Professional jealousies

9.36 A recurrent feature of life at Kerelaw appears to have been the schism between the Secure Unit and Open School. Staff in the Secure Unit were described by some as elitist and insular and an “us and them” culture was said to have developed between the two. This became particularly acute after changes in the management and staffing of the Secure Unit were made by the Principal in late 1999. This was reflected in low morale in the Open School and a perception that the Secure Unit was prioritised for resources and staff training. A number of professional jealousies, rivalries and personal animosities developed around this issue. Workers talked openly about the emergence of “camps” within the staff group.

9.37 These divisions became fault lines which began to define the school and set the context for a number of the professional and personal relationships which developed. Managers across the Open School and Secure Unit, and often between units within those settings, appeared to be split, and no coherent vision for the school was evident. Managers had been given significant autonomy to run their units following a review of staffing in 1994 undertaken by Strathclyde Region. We were told this was with a view to developing leadership capacity at team leader level. Unit managers were supposed to take on some cross-establishment roles although that does not appear to have happened. Instead, a degree of competition among units was encouraged. The rationale for this lay in providing a stimulus to raising standards, but the downside was that it appeared to work against building the unified, inclusive approach to taking the school as a whole forward which was required.

9.38 The impact on a day-to-day basis was important and the Inquiry was surprised by the accounts provided by a range of former employees. We heard that some managers bullied and undermined staff. Favourites were identified and those whose faces did not fit told us they felt excluded and scapegoated. A general lack of trust appears to have existed across the campus, with attitudes being displayed which were inappropriate. Some of those who gave evidence alluded to a culture of fear and blame within which cliques appear to have thrived. A number of staff talked about not being welcomed when they started at the school or when they moved from one unit to another. The negativity and unpleasantness associated with this behaviour was troubling for staff and, we deduce, for residents too.

9.39 Divisions were evident between night staff and day staff. We heard of the isolation of the night staff, who were often not considered to be an integral part of the care team workforce. They did not have the same access to training or development as the day staff and the important work they were tasked to undertake was largely unacknowledged. However, serious concerns were evident about the practices of the night-shift at different points, and it was believed by many day staff that night staff closed ranks when it suited them. The Inquiry considers that factionalism led to collusive behaviours which hindered an effective resolution of concerns about certain night-shift staff.

9.40 The Inquiry heard evidence of undermining behaviour, with some managers playing workers off against one another. There appears to have been continual gossip and rumour-mongering at the expense of particular staff. Some of those we spoke to talked about being ignored by peers, insulted or given pejorative nicknames. Such behaviour does not appear to have been effectively challenged and in many cases was condoned. Two workers described more sinister attempts to undermine them, including being “set up” and placed at physical risk during shifts. An indication of how difficult it must have been for people to speak up

about matters of concern was given by ex-employees who said they had been called “grasses” or were believed to be “plants”, placed by Glasgow City Council.

Personal relationships

9.41 The factionalism among staff was reinforced by personal and familial relationships. We were told that particular staff groups regularly socialised together and formed close and intimate relationships. Family members and friends drawn from the local communities were often employed together. We were told in evidence of an occasion when a manager would have been involved in assessing a close family member for promotion but for the intervention of a member of the Personnel Department in Glasgow. Some staff told us that access to training and career progression opportunities had been corrupted. Staff associated with powerful or influential cliques were said to benefit unfairly from such opportunities, although we found no documentary evidence to support that claim. One witness talked of “power play” with overtime, which for some was a welcome opportunity to earn more.

9.42 Professional boundaries were compromised, as young people were often aware of inappropriate relationships between staff. Relationships of this kind swayed professional judgement and got in the way of work. We learned of one case where a resident was confronted by a worker over behaviour which had been directed not to the worker himself but to his domestic partner.

Impact on safeguarding children

9.43 Some staff talked about the difficulty of “raising their head above the parapet” over concerns they had. Some said they did not know whom to go to with concerns about peers as personal connections meant that confidentiality could not be guaranteed. That being so, there was a fear that their “card would be marked”. There appears to have been a lack of faith that managers would investigate and resolve concerns. Some talked about a reluctance to raise issues or support young people. It was stated that they would face disapproval from colleagues and possibly direct sanction and disadvantage. Many offered examples of concerns about child care practice which had not been properly addressed, and it was suggested that personal allegiances and loyalties had played a part.

Whistleblowing

9.44 The Edinburgh Inquiry, the Fife Inquiry¹⁵ and the Kent report all identified the need for clear whistleblowing policies and procedures for staff and complaints procedures for children. Despite the fears and anxieties noted above, some staff in Kerelaw did use the whistleblowing procedures. Whistleblowing led to the Millerston investigation, although the initial concern was about bullying of staff, not young people. The Inquiry was surprised at the number of people who described themselves as being “the” whistleblower, in the sense of having brought major allegations out into the open. We were not able to establish how many employees used formal whistleblowing procedures, nor indeed how many understood what those were. The culture at Kerelaw could not be described as open, but certain determined staff did find ways to sound the alarm at different times, although without any lasting impact

¹⁵ Black, A and Williams, C *The Fife Council Independent Inquiry Report* (2002)

until 2004, when senior staff in Glasgow took action in response to the information they received.

9.45 Some Kerelaw employees were dismissive of the accounts given by whistleblowers and those who gave evidence at subsequent disciplinary hearings. It was asserted by some that such accounts had been affected by personal loyalties and that they lacked credibility. Some people who were subject to fact-finding and disciplinary procedures stated that they were maliciously implicated in abuse because of the factional, skewed interpersonal agendas at play. The Inquiry was struck by the extent to which personal animosities and resentments against others came through in the evidence of certain individuals and by the determination of some former workers to minimise and disparage the whistleblowers. It is clear that it would not have been easy to be a whistleblower at Kerelaw, and that considerable courage would have been required to raise and sustain complaints about colleagues.

Performance management

9.46 In the 1990s there was no effective performance management or staff appraisal system at Kerelaw of the kind that was already in place, or becoming established elsewhere. In this respect Kerelaw was not unique in the social care system.

9.47 There are a number of obvious difficulties involved in developing formal performance management systems for social care staff, or teachers, whose work is firmly centred in the field of social and human interaction. What outputs, outcomes, indicators, objectives and targets may be appropriate or desirable is a complex question which has given rise over the years to much debate and will continue to do so. This report is not the place to continue that debate. Deciding the extent of an individual's own personal contribution to delivering outcomes and meeting objectives or targets can also be a challenge where the client group has complex needs, and where responsibilities are shared with others.

9.48 Whatever difficulties there may be in defining and assessing measurable outcomes for complex services, or agreeing the contribution of different agencies to the desired results, defining the responsibilities and setting out the objectives of a manager is potentially more straightforward. Giving direction, setting and communicating standards, obtaining and using management information, monitoring trends, ensuring staff have the skills to do their jobs, complying with corporate policies, and budget management are among the generic requirements of the management role, particularly at senior level, regardless of the business or service involved. Personal performance plans should be capable of reflecting aims, objectives and accountabilities within such generic managerial responsibilities, and should be able to provide a basis for performance management and review.

9.49 For managers at Kerelaw, however, personal performance plans, with clear responsibilities and agreed aims or objectives capable of assessment and review by more senior managers, were not a feature. Yet the question of what exactly were the responsibilities of individual senior managers was at the heart of much of the argument in the consideration by the Employment Appeals Tribunal in 2008 of the Principal's appeal against dismissal. The Inquiry considers that the lack of a robust performance management framework for senior managers at Kerelaw was a serious weakness, which contributed to the failures there.

Supervision

9.50 The practice of professional supervision in social work is well recognised, fully documented and often researched. For social care staff at Kerelaw, and for managers at Kerelaw and externally, as elsewhere, supervision would be important in developing and controlling the quality of the service, taking account of the needs and rights of the young people and staff performance. Unison in 2006 described professional supervision in Social Work as “the key process for balancing professional autonomy with responsibility to the client, professional ethics and standards along with accountability to the agency and society at large”.

9.51 Through supervision, the line manager is expected to meet regularly with staff to address certain organisational, professional and personal objectives. These objectives are competent, accountable performance, continuing professional development and personal support. Formal supervision involves recording what has been discussed and following this up at subsequent sessions.

The importance of supervision

9.52 The emotional impact of working with challenging and vulnerable young people is considerable. There is a risk of staff burn-out, with the attendant potential risk of a “hardening” in approach. Stress or upset in the personal lives of care staff may have a greater impact on their work than in some other occupations less dependent on at times sensitive human interaction. Staff at Kerelaw would have needed to be supported emotionally as well as practically. They had to be able to react appropriately to all kinds of emotionally challenging circumstances. Good supervision can help a worker to process and reflect, learn new ways to respond and – importantly - send a message to the line manager that he or she is not coping.

9.53 Morrison (1993)¹⁶ suggested that the pace of change in social work, coupled with constant and acute resource problems, made it hard to sustain supervision to reasonable standards. He noted that some senior managers, especially those from outside social work, questioned the meaning and value of supervision. At the same time, the drive for better quality assurance, competence-led training and messages from child abuse inquiries all demanded higher standards of professional competence and public accountability. Morrison argued that this could only be done through effective supervision of staff:

The management of rapid change and the development of a skilled, confident and adaptable workforce, whose task is to deal daily with pain, poverty and powerlessness, will only be fully realised if staff are regularly and skilfully supervised.

Staff supervision at Kerelaw

9.54 The evidence to the Inquiry was that staff at Kerelaw did not receive formal supervision on a regular basis. Some former staff told us there had been times when they had received no formal supervision at all. Others said they had supervision infrequently, in one case only 3 times over a period of many years. Most of the former residential care staff who

¹⁶ Morrison, Tony *Staff Supervision in Social Care* (1993) Pavilion

talked about supervision were aware of its purpose and recognised this was a real deficiency at Kerelaw.

9.55 One former manager told us that she had been sent on a training course and this enabled her to offer better supervision to her staff. However, another former senior manager at Kerelaw expressed the view to the Inquiry that formal supervision within residential care was not as important as in fieldwork, as the residential task often took place in the presence of line managers. This represents a very limited view of the nature and purpose of supervision which ignores the individual support and challenge staff need to receive in private.

9.56 A former senior manager in Glasgow City Council expressed a similar view about supervision in the fieldwork setting. He considered supervision could reinforce poor practice and suggested that the informal daily, and sometimes hourly, contact social workers had with their line managers was better. This seems to the Inquiry also to be a narrow view of the potential of formal supervision. With disagreement among managers as to the value of supervision, it is hardly surprising that the institutional commitment at Kerelaw to making supervision happen and to its quality appears to have been poor.

9.57 The Inquiry read examples of supervision notes. They were very brief, followed a set pro forma and lacked detail. We noted that many had been prepared as part of portfolio submissions for Scottish Vocational Qualifications (SVQs). Questions about the regularity of supervision were raised with the Principal by the external manager in March 1998 following statements about its deficiencies by staff in fact-finding interviews. Lack of supervision was also a significant issue identified in the Review of Night Care carried out that year. The absence of regular formal supervision was noted in inspection reports over the years. North Ayrshire Council had noted deficiencies in their inspections of the Open School in 1997 and of the Secure Unit in 1998. In his paper on a “New Kerelaw” in early 1999 (see Chapter 10) the recently appointed Principal noted that supervision:

...should have regular dedicated time, be recorded and be thorough. High quality supervision and high quality practice are inextricably linked.

9.58 Towards the end of 1999 an action plan following up the Night Care Review included improving supervision at Kerelaw. A training day for unit managers and deputy unit managers took place at the beginning of September the following year. Two months later new guidelines for supervision set out how frequently this was supposed to happen for all staff. Henceforth supervision was to be pre-planned and monitored by line managers on what was termed a “look-see” basis.

9.59 It is not clear what sustained improvement took place, although there seems to have been some increase in frequency. However, in the report of its inspection of the Secure Unit in March 2001 North Ayrshire Council noted that the planned programme of supervision was not being applied consistently, and in its inspection of the Open School in July of the same year it noted that poor records made it difficult to tell if formal supervision took place. In its inspection of the Secure Unit in February 2002, North Ayrshire Council noted that there were still deficiencies in supervision. Even when inspectors found evidence that supervision was taking place, it was generally not happening often enough nor recorded appropriately.

9.60 In May 2002, a Management Review and Development Day identified revision of the format of supervision and its incorporation in staff development plans as one of a number of

priorities for action. We were not able to establish from written records or oral evidence the extent to which this was implemented. In the Care Commission/HMIE inspection of August 2004, the arrangements for formal supervision of care staff were evaluated as unsatisfactory. To what extent that reflected the removal of a number of managers and staff in 2004 it is not possible to say. It may be that, as with a number of other proposed changes over the years at Kerelaw, disagreements, operational pressures and a lack of sustained management follow-through, got in the way.

The potential of supervision

9.61 The 21st Century Social Work Review *Changing Lives*¹⁷ suggested that one of the strengths of social work in the past had been using professional supervision to challenge practice and discuss solutions to complex problems. There was concern during the review that some social work managers were using supervision to take accountability for social workers' actions rather than promoting and enabling personal and professional accountability on the workers' part. Many social workers reported that supervision had become little more than workload management.

9.62 *Changing Lives* sets out a new approach to supervision. It suggests that "consultation" better describes a process which supports and challenges, rather than merely supervises, professionals. The new term "consultation" includes 3 core elements: performance management; staff development; and staff support. Its aim is to enable practitioners to deliver high standards of practice and improved outcomes for service users. However, the effectiveness of "consultation", like "supervision", will be dependent on the commitment of managers at all levels to engage with appropriate frequency and professionalism. That commitment was not evident at Kerelaw even though deficiencies in supervision had been identified by Inspectors and plans were made to improve practice. Nor was this commitment evident from external managers of Kerelaw. The Inquiry considers that robust performance management and supervision are key to reducing the risk of circumstances similar to those at Kerelaw occurring elsewhere.

Conclusion

9.63 The culture at Kerelaw, with its emphasis on control, and the physical capacity to enforce it, was an important factor in the circumstances which led to abuse taking place largely unchecked over a prolonged period. This culture was readily reinforced by a local workforce with shared attitudes and behaviour. There was no effective system of performance management or appraisal, and failures in supervision played an important part in what went wrong at Kerelaw

¹⁷ *Report of the 21st Century Social Work Review* Scottish Executive (2006)

10. CAPACITY FOR IMPROVEMENT

10.1 At the time of transfer to Glasgow City Council in April 1996, Kerelaw had been without a substantive Principal for several months. The Deputy (Secure Unit) had been acting Principal since the Autumn of 1995, and he remained in charge until late 1997, after 2 unsuccessful attempts by the Council through open competition to make a substantive appointment. At the end of 1996, the SMT at Kerelaw was reduced to 4 with the retirement of an Assistant Head in the Open School. He was not replaced as a result of a review of Kerelaw and 3 other residential centres by Strathclyde Regional Council in 1994 (see paragraph 13.7).

10.2 The SMT was destined to experience significant churn over subsequent years. This was not helpful to the construction of a shared vision of what Kerelaw's direction should be in a new era of child care and protection, and change in the local government landscape. It would be untrue to suggest that no one considered that improvements at Kerelaw were required or tried to take up the challenge of change. There was recognition by certain individuals that the quality of care needed to improve, that the world was changing and that cultural issues needed to be addressed.

Tensions over change

10.3 The Deputy (Open School) at the time of the transition from Strathclyde Region to Glasgow City Council was aware of this and she sought among other things to improve staff access to training, to integrating the night staff with the daytime operations of the school, and to introducing new approaches to meeting the needs of young people. She also established a throughcare project to support young people leaving Kerelaw. In all of this she had some supporters. But she also faced opposition, as we noted at paragraphs 9.17, and a number of former staff gave evidence to the Inquiry about this. One stated that:

[the Open School Deputy] was a breath of fresh air and had a particular influence over the women working at Kerelaw.....[she] gave power to the young people and that shell shocked some of the staff who had maintained a control regime for the last 20 years.....but she wanted change to happen too quickly and didn't manage it well, so there was great resistance in some quarters

10.4 Another noted that:

[Her] nurturing and progressive approach did not suit everyone.....

while one who supported her summed up the challenges she appears both to have posed and faced:

[She] was both the best and worst manager he had ever had, sometimes in the same day. She was committed to the school, to young people and the task. She made Kerelaw an interesting place to work but there were lots of tensions between her and the other managers.

10.5 We heard from a number of sources about tensions during this period between the Deputy (Secure Unit) and the Deputy Head (Open School) around aspects of practice, and that staff allegiances formed round one or the other. A report by North Ayrshire Council on

its September 1996 inspection of the Open School, although positive about its Deputy, referred to relations between senior managers as strained. It may be an oversimplification to describe the opposing views as being between a disciplinarian and a child-centred, libertarian approach, but they appear to have been very polarised. One former member of staff encapsulated what several others also told the Inquiry, that there were:

..... tensions between [the two Deputy Heads] ...their relationship was awful and generated schisms within the staff group. [one] represented a more liberal, progressive way of thinking but.....would go off and do things without consulting anyone.....

10.6 The files and oral evidence to the Inquiry give an indication of the obstacles to progress and of who were not supportive. While more progress might have been made had the Deputy (Open School) gone about things differently, it appears to the Inquiry that her counter-cultural values would have been difficult for some managers and staff, regardless of her personal style.

10.7 The post of Principal was advertised again in September 1997, but no appointment was made. The acting Principal then asked for, and returned to, his former post as Deputy (Secure Unit), the role to which he had been recruited in the early 1980s. To fill the vacancy, the Council appointed another acting Principal who, as an Assistant District Manager, had been undertaking the role of external manager of Kerelaw, on behalf of the District Manager. We discuss external management arrangements in Chapter 13.

“Less than child friendly”

10.8 The Inquiry learned that the Deputy (Open School) had voiced concerns about the culture at Kerelaw to managers in the Social Work Department, although we were told that these were not sufficiently specific to enable action to be taken in respect of particular individuals. Nevertheless, following complaints by certain placing authorities and the subsequent investigations to which we referred at paragraphs 7.7-7.9, the Head of Service wrote in February 1998 about her concerns over Kerelaw to her line manager, the Deputy Director of Social Work. In her memo she described a culture that was “less than child friendly”.

10.9 In early March 1998 the Social Work Department re-issued its *Care and Control Policy* for residential care, partly in response to the concerns described above. It referred among other things to the aim of a “safe and caring” environment, and made clear that workers should not participate in horseplay with young people on the grounds that those who had experienced abuse might interpret physical contact as “threatening or oppressive”. The document also set out rules on searching, and required each residential unit to have a development plan. Correspondence from the Social Work Department to the acting Principal referred to “worrying signals” about TCI and to potential use of a range of behavioural management techniques.

10.10 The acting Principal reported on a number of actions taken in response to the concerns raised, including circulating the re-issued *Care and Control Policy* to all staff, tightening complaints procedures, and ensuring proper recording of violent incidents. He also asserted that supervision took place more regularly than had been suggested by staff interviewed

during fact-findings. Nevertheless, as we have described in Chapter 9, insufficient supervision continued to be a theme in inspection reports and reviews.

10.11 In June 1998 the acting Principal circulated the Council's *Residential Child Care Staff Code of Practice* with a requirement that managers discuss it with staff, who were to sign to confirm that discussion had taken place. The Code of Practice set out what was and was not acceptable conduct and covered professional and personal boundaries, professional conduct, role modelling, and children's rights. It made clear among other things that staff should show respect for young people and their families, and in dealings with colleagues. It covered the use of language, relationships, and contact with young people, and action to take if negligence or abuse was suspected. It referred to lessons from reports and Inquiries.

An outside appointment

10.12 In early 1998 the Deputy Head (Secure Unit) had taken extended sick absence and in April 1998, the post of Principal had been advertised again. This time an external candidate, with Secure Unit experience in England, was selected in competition with internal applicants. When he took up post in September 1998, he appears to have encountered some resentment over the appointment of "an outsider", but he managed to establish a working relationship with most of his senior managers, and believed at the time that he had reasonable support.

10.13 We were told in evidence that the new Principal had been impressed by how the selection process had been conducted but that, before accepting the appointment, he had visited the Secure Unit. He had considered the conditions there appalling and an important consideration in his acceptance of the post as Principal was an assurance given to him by Glasgow City Council that the Secure Unit was going to be rebuilt. In July 1996 the Government had published *A Secure Remedy: a review of Secure Care in Scotland*¹⁸ which had criticised Kerelaw's Secure Unit, and the Council had agreed in principle to redevelopment, subject to negotiations with the Government over funding (see also paragraphs 13.42 to 13.44).

10.14 Taking forward the planning for redevelopment and improving the running of the existing Secure Unit were high priorities for new Principal throughout his tenure. However, his arrival also brought a fresh external perspective on Kerelaw as a whole and an opportunity for general change. Although he was unaware prior to his arrival of the concerns previously expressed by the Deputy Head (Open School), he began to harbour his own concerns about practices in Kerelaw, including poor staff recruitment and staff cliques. A number of issues raised in the 1997 fact-finding investigations (see paragraphs 7.7 and 7.8) about restraints and sanctions remained to be addressed. An audit covering logs and files, controls, supervision, absence management, care programmes, recording, and follow-up, and other matters was put in hand. The Inquiry saw records which indicate management action on a number of fronts from telephone usage to health and safety, all of which suggest that a new broom had arrived. As with many new brooms, the actions he took were not always or universally welcomed.

10.15 In response to concerns related to the "riot" in 1998 (see paragraph 7.10), a Review of Night Care was undertaken in conjunction with the Social Work Department to address what management considered to be a large divide between day and night care staff. The

¹⁸ *A Secure Remedy A Secure Remedy: a review of Secure Care in Scotland* The Scottish Office (1996)

findings were submitted in March 1999 and as we have noted, resulted in the consolidation of additional posts on night-shift which had been created on a temporary basis after the “riot”.

10.16 The Review found that night staff felt isolated and that there was confusion over roles, boundaries, expectations and responsibilities. It proposed the attachment of night staff to particular units and greater integration with day staff under single unit management, which was to be strengthened. The aim of uniting day and night work was not fully achieved. The review identified deficiencies in staff supervision, which we discussed in Chapter 9. It also expressed concern about recruitment and the lack of regular assessment of temporary workers, and recommended improvements.

“A New Organisation”

10.17 We were told that senior managers in Glasgow saw the new Principal as an important appointment which would put Kerelaw on the road to improvement. That he understood that improvement was needed at Kerelaw is clear from a paper entitled “A New Organisation” which he sent to the Head of Service in February 1999. This sent a signal that, if Kerelaw had previously seen itself as standing off from the Social Work Department, this would need to change:

We are all part of Glasgow City Council Social Work Department and it is important that we strengthen and develop existing links. Kerelaw School must continue to have a strong individual identity as an integral part of Children and Families Services.

10.18 This wish to “open up” Kerelaw and link it more closely into the Glasgow City Council management structure does not appear to have been popular, including, so far as we could tell from evidence, within parts of the SMT. However, some managers approved of his involvement of Kerelaw in certain HQ groups and it seems that he did achieve greater integration with management in Glasgow than had previously been the case.

10.19 The Principal’s paper identified most of the problems which Kerelaw seems to have faced between 1996 and its closure. It acknowledged examples of good child-centred practice across the school, but stressed the importance of commitment to developing practice. Staff development and training were identified as a high priority. In particular, the paper emphasised the need for a more inclusive culture in which there was more working together and a stronger sense of Kerelaw having a single identity rather than a cluster of individual units. It also identified and spelled out the cultural challenge in the following terms (original underlining):

We have to work towards promoting an inclusive culture which values the individual and is clear about the service objectives. An inclusive culture requires everyone to have a clear understanding of roles, boundaries and decision making processes. An inclusive culture requires a commitment to service provision and an end to divisive splits. An inclusive culture requires everyone to contribute to the ongoing process of development. An inclusive culture requires everyone to work within a framework of equal opportunities and anti-oppressive practice.....At the heart of any organisation is the culture. We must begin the development of a new culture at Kerelaw

School. Managers should be approachable and open to being challenged as well as challenging in a safe environment.

10.20 Consistent with his aspiration for a more inclusive culture, the Principal widened attendance at management meetings to unit managers, a change not welcomed by all members of the SMT. In early 1999 a School Development Plan was produced, but the Deputy Head (Open School)'s throughcare initiative was abandoned, mainly for budgetary reasons, and against her wishes. In March 1999 the Deputy (Open School) went on sick leave from which she did not return. When it became clear that her post was likely to remain vacant for some time, an acting Deputy (Open School) was appointed in early June.

10.21 In late 1999, the Principal reallocated SMT responsibilities by switching the Deputy (Secure Unit), who had returned to work, with the acting Deputy (Open School). This was not welcomed by the former, and was to cause division in the SMT thereafter. The new acting Deputy Head of the Secure Unit was confirmed as substantive Deputy (Secure Unit) later. According to evidence given to the Inquiry, the switching of Deputies was followed by the transfer of a number of staff from the Open School to the Secure Unit.

10.22 There had been criticisms by HMIE, following an inspection in September 1999, of the Unit's ethos, the structure of the educational curriculum, the effectiveness of leadership, and staff development and review, all of which were considered unsatisfactory. Concerns had also been raised during the Summer of 1999 by an advocacy worker. The management and staffing changes were accompanied by the promotion of arrangements to establish and fund psychologist-led programmes in the Secure Unit, intended to improve the management of young people in secure care and to make it more child-centred. Nevertheless, some managers took the view that the changes were damaging to the Open School as they removed its best staff, although evidence to the Inquiry established no consensus on that.

10.23 There was, however, a consensus that switching the two Deputy Heads was extremely divisive, destined to set back the achievement of the more inclusive culture which the Principal wished to achieve, with fewer barriers and a stronger sense of single identity. Although we were told in evidence that the outgoing Deputy (Secure Unit) "did not refuse" to move to the Open School, relations between him and the new head of the Secure Unit were unhelpful to the cohesion of senior management, and encouraged factional behaviour. Most former managers and some staff who gave evidence to the Inquiry referred to the fact that the two did not get on, and to the dysfunctional relationship in the SMT this created. The effects of this were not subsequently addressed.

10.24 Various changes in operations and procedures were introduced during 2000, and discussions with the Social Work Department on the proposed redevelopment of Kerelaw continued. In April 2000 a letter from the Council's Education Department to HMIE in response to the previous September's inspection which criticised the Secure Unit made clear that there was no likelihood of money being found to implement the curricular recommendations in the report. It cited the discussions taking place with the Scottish Executive on the redevelopment and possible resiting of Kerelaw to within the Glasgow boundary as a factor in this.

10.25 In May 2000, a redevelopment brief, part-funded by the Scottish Executive, was issued to the Council's Building Services, who later produced a Kerelaw Redevelopment Study report, which set out a detailed specification for a new build and the aims of the new

establishment. It noted six sites within Glasgow which had been considered, but proposed a shortlist of only one, to which was attached an explicit warning about likely local opposition, a public inquiry, and planning delays. This warning was, we deduce, influential. Much later, when the decision to go ahead with rebuilding the Secure Unit was taken, it was on the basis that it would take place on the existing site in Ayrshire.

10.26 Written records and oral evidence to the Inquiry confirm that a number of reviews and initiatives to improve the management and operation of Kerelaw, and the Secure Unit in particular, were promoted between late 1998 and the end of 2000. As with earlier attempts at change, and consistent with the experience in many organisations, these encountered resistance, although the report of the inspection of the Open School by North Ayrshire Council in October 1999 had indicated that staff were positive about the new Head. One former member of staff who approved of the changes took the view, in evidence to the Inquiry, that [the Principal]:

did move things forward ensuring staff had more opportunities for training and developing practice..... He brought [more psychology support] into the school and got agreement that programmes took place during school time – this was quite a change.....and [he] finally managed to turn the tank around

and we were told that in the Social Work Department:

there was a view that he had turned things around, that things were better at Kerelaw.

10.27 A contrary view, based partly on the priority given to the Secure Unit, the management and staff changes associated with that, and a perception that the Principal himself had “favourites”, was that:

He caused an enormous divide and a lot of damage.

Further change at the top

10.28 Within a short while there was more change, when the Principal moved to Social Work HQ to take over as Head of Service. Following competition, he was succeeded in December 2000 by the Deputy (Education). Although his successor as Principal did not reverse his controversial switch at Deputy Head level between the Open School and Secure Unit, he quickly discontinued his predecessor’s practice of including unit managers in senior management meetings. This change was welcomed by the Deputy (Open School). It is hard to quibble with a Principal’s right to determine who should attend his meetings, but it is unfortunate, with hindsight, that the opportunity for leadership and communication throughout Kerelaw which a more inclusive approach to management meetings might have created was so quickly discarded.

10.29 It is apparent from papers seen by the Inquiry and from oral evidence that many staff welcomed the regime change. Comments in the context of an inspection in 2001 refer to the new Principal working to restore morale among certain staff. A number, it seems, found his predecessor’s approach to achieving culture change challenging, and certain administrative changes had caused upset. We were told in evidence that, after the change in Principal,

progress in some areas appeared to lose pace, with a number of planned improvements, such as in supervision, proving difficult to implement in full.

10.30 The Inquiry was told that relations between the new Principal and his predecessor began to cool. This was partly on account of the new Principal's unhappiness over the latter's alleged failure in his new role as Head of Service to "protect" Kerelaw from what certain managers and staff saw as an increasingly difficult client group. There was concern over the balance between young people from Glasgow and those from other authorities in the Open School, and we saw correspondence in May 2001 in which the Principal stated that for staffing reasons Kerelaw was only just coping with the current resident mix. His perception was that the Council was using Kerelaw as an emergency resource centre. This problem was in the Principal's eyes compounded by the delegated external management arrangements which the new Head of Service put in place, and which we discuss at paragraphs 13.16-13.17.

10.31 In the Summer of 2001, the Head of Service was reporting to committee that following staffing increases at Kerelaw, Glasgow City Council's usage would be held at 50%. However, by the Autumn the proportion had risen to 56%. According to senior managers at Kerelaw, by 2003 the proportion of places taken by young people from Glasgow reached 80%, although the statistics on resident numbers and place of origin provided by Glasgow City Council to the Inquiry do not substantiate this. We accept, however, that the proportion of admissions from Glasgow increased, as several sources referred to this in evidence, and we did see paperwork prepared by the Principal at the time which set out the figures. Admissions were reduced in April 2004 following representations by the Principal to external managers.

10.32 The challenge of numbers and resident mix appears to have been a significant preoccupation from 2001 onwards, and may partly explain the slow pace of change. A review of staffing in 2001 resulted in the provision of substantial additional resources, as we note at paragraph 13.9. A successful recruitment exercise for deputy unit managers for deployment at night, and for basic grade workers, followed. The review was the first since 1994.

10.33 A short period of stability in the SMT was disturbed in February 2002, when the Deputy (Open School) was moved temporarily to Centenary House. His position was backfilled by a secondment from HQ, which lasted until the Deputy (Open School) returned at the end of the year. In May 2002, the Principal sent a memo to the external manager outlining a number of priorities following a review of the Strategic Development Plan. These included establishing cognitive skills and anger management programmes in each unit, and reviewing the complaints procedure and external advocacy services, with particular reference to staff training and timescales for replies to young people. Other priorities included a review of the senior management structure, establishing a timetable to achieve universal SVQ training for staff, the appointment of a training officer to work on staff development plans, and revision of the supervision format for incorporation in staff development plans.

10.34 These priorities reflected concerns raised over preceding years in reviews and inspection reports. A Training Manager was seconded to Kerelaw in June, but was in post for only a little over a year. An additional Head of Education post for the Open School was agreed, but a proposed new post of senior Depute Principal was not. The Principal's memo referred to the need to locate Kerelaw firmly within the spectrum of child care and staff support which Glasgow offered, and suggested the re-establishment of the Kerelaw Management Group. This was a "third tier" group involving Kerelaw senior management and

external management which had been set up by the previous Principal and had met twice a year until the Summer of 2001. It appears that this suggestion was not followed up.

10.35 In January 2003 the Principal's Report to the Social Work Department for 2002 recorded progress against the Development Plan. It reported that a Cognitive Behaviour Programme and a Violence Reduction Programme had been introduced in the Secure Unit and that a worker from Who Cares? was in weekly attendance at the school. Successful recruitment of additional care staff for the Open School and deputy unit managers for night-shifts was noted. The report recorded the qualifications held by staff and looked ahead to likely Care Commission requirements. It commented on the load on the SMT, the size of which the Principal contended was only half of any private sector comparator.

10.36 For the future, the report identified among other things a need to improve the condition of the Open School, an aspiration to extend programmes to the Open School, to raise pupils' educational attainment, and for further training. It acknowledged that most staff had not undertaken refresher training for TCI and that it was vital that this was addressed in 2003 and 2004. The Principal's Report was discussed at a meeting in Glasgow in May 2003. Around the middle of 2003, the additional Deputy (Education) was finally appointed at Kerelaw, thus providing a separate Head of Education in each of the Secure Unit and Open School. This returned the SMT to the size it had been at the point of local government reorganisation in 1996.

HMIE concerns

10.37 Meanwhile, concerns had been growing in HMIE about the follow-up to the report of its inspection of the Open School in September 2001, which was published in February 2002. The inspection had judged a number of aspects of the education provision to be good, but 15 aspects were evaluated as "fair", an assessment which HMIE made to indicate significant weaknesses. The provision of residential accommodation and facilities and the use of assessment to guide the teaching process were evaluated as unsatisfactory. There were eight main points for action on the fair and unsatisfactory aspects, and the school and Glasgow City Council were asked to prepare an action plan indicating how they would address these.

10.38 There appear to have been difficulties with the action plan, which required a meeting involving HMIE, the Director of Social Work (at that time also Director of Education designate) and the Principal of Kerelaw, and the later attendance by an Inspector at a meeting with teaching staff at the school. Despite these meetings, concerns continued up to the next inspection in November 2003, which was the first integrated inspection involving HMIE and the Care Commission, and was led by the latter.

10.39 The report of the integrated inspection was published in April 2004. Progress towards meeting 5 of 8 action points was evaluated as fair and progress on 3, including management, was unsatisfactory. It was noted that on these little progress had been identified since 2002 and the school and the Council were again asked to prepare an action plan indicating how they would address the main findings of the report. The report also noted four key strengths. However, staffing levels in the units were said to be inadequate at times and there were concerns around climate and relationships, meeting pupils' needs, personal and social development and the structure of the curriculum, which were evaluated as "fair". Although the school had received additional funding from the Scottish Executive in 2002 for the

improvement of educational attainment, planning for improvement was evaluated as unsatisfactory. The Inquiry learned that within HMIE informal concerns had been expressed about staff morale, poor direction and lack of management capacity.

10.40 The Inquiry learned that the Head of Education in the Open School raised concerns with the external manager following the April 2004 report. An action plan was prepared and sent to senior Education and Social Work management without, so far as we can establish, any comment by the Principal. We are not aware of any subsequent discussion, although by then the Millerston investigation was under way, there were signs of strain affecting the Principal and the SMT, and events leading to the decisions by the Council to suspend a large number of staff following the Millerston report began to move quickly.

10.41 In mid-June 2004, the Principal was moved for management reasons, as noted at paragraph 7.20, following the external manager's report to the Directors of Social Work and Education on emerging allegations of abuse of young people by staff. As had happened in late 1997, the person responsible for external management was appointed acting Principal of Kerelaw and remained in post until the closure, first of the Open School at the end of 2004, and then, some 15 months later, of the Secure Unit.

External management changes

10.42 There was also considerable change in the Social Work Department over the period. This had an effect on external management arrangements. Following restructuring, formal responsibility for external management of Kerelaw passed in 1998 from the District Manager to the Head of Service, a post which was equivalent in salary terms to that of the Principal. However, for practical purposes external management, in the sense of regular, direct liaison with Kerelaw, was delegated to a Principal Officer, Residential Child Care.

10.43 For a variety of reasons, including the wider responsibilities of the Principal Officer concerned, delegation proved impractical, and for the next two years the Head of Service had to take the responsibility herself, during what was to be a very testing time. She was appointed Deputy Director Children and Families and Criminal Justice in mid-2001, and her place was taken by the Principal of Kerelaw. He designated a Principal Officer to take on day-to-day external management responsibilities for his former establishment. For reasons explained at paragraphs 13.16 and 13.17, the new Principal considered this arrangement inappropriate. This became a bone of contention and did not encourage a mutually supportive relationship between Kerelaw and HQ.

10.44 In late 2001, the Deputy Director for Children and Families and Criminal Justice left the Council and a new Deputy was appointed. In early 2002 the Head of Service resigned. The vacant post of Head of Service was filled in May 2002. The new Head of Service continued with the day-to-day external management arrangements which he had inherited. In August 2003 external management arrangements for Kerelaw were supplemented by the appointment of an acting Residential Services Manager, as a "consultant". From the Spring of 2004, the "consultant" acted up as Deputy (Open School) after the latter became ill. The Deputy Director for Children and Families and Criminal Justice left the Council in 2005. The Head of Service also left. There were also 4 different Directors of Social Work between 1996 and the closure of the Secure Unit in 2006.

Training and development

10.45 Staff training and development should have played an important part in modernising Kerelaw, ensuring that its service was compliant with the new regulatory framework and responsive to changing expectations. Professional social work training since the 1970s aimed to provide a common knowledge base and transferable skills across all practice areas. This included all care groups - children, families, adults, older people - and all settings, whether community or residential. The emphasis was on ensuring that fieldworkers became qualified. There was no drive for residential care staff training until much later.

10.46 As a result, residential child care has struggled to achieve a qualified workforce. A significant issue has been deciding what qualifications best prepare potential residential care staff for the task. The debate about improving the training and qualifications of residential child care workers has gone on for many years and continues today. Much of the debate centres on what should be the core underpinning theories that staff need to learn about and what should staff know in order to understand children and to develop skills.

Vocational qualifications

10.47 The Skinner and Kent reports endorsed the use of vocational qualifications as the basis for a continuum of education and training. Skinner recommended that priority be given to induction training for new staff, Higher National Certificate (HNC) and SVQ for existing staff, and the Dip SW for managers. Kent noted 5 years later that progress towards a qualified workforce had been very slow.

Registration

10.48 The requirement for residential child care staff to be qualified was finally introduced under registration procedures in the 2001 Regulation of Care (Scotland) Act, and all residential child care workers will require to be registered by September 2009. Residential care workers with a range of different relevant qualifications will be able to register, but the minimum has been set at relevant SVQ 3 with evidence of any HNC-level qualification. The decision to accept an HNC regardless of the subject content has caused some concern within the residential child care sector, as it recognises the need for relevant skills without the complementary knowledge base.

Kerelaw

10.49 During the Inquiry, former staff talked to us about their experiences of training. Prior to the early 1990s, there appears to have been very little training offered to staff at Kerelaw. This improved in the mid-1990s due to the concerted efforts of the Deputy (Open School). She was instrumental in arranging for a basic introductory child care course “Signpost” to be offered to all staff. Many former staff told us they had really welcomed this course. We were told that she:

...introduced a training/induction programme which was very good. She was obsessive about it... ..was good at training.

10.50 Although most residential care workers started at Kerelaw without relevant qualifications, some described being given good opportunities and many did go on to gain

SVQs and HNCs. A smaller number gained Dip SWs and management qualifications. Others talked of difficulties in securing access to training and having to fight for the time to complete even the most basic courses. Training of night staff, for whom there seem to have been few opportunities, posed particular problems. Some staff came to Kerelaw already qualified in social care or social work. Others had other relevant qualifications, for example in nursing or youth and community work.

10.51 Over time, a range of courses was offered to staff at Kerelaw from the practical, such as first aid and health and safety, to more specialist courses such as drug awareness and cognitive skills. Some of this training was offered “in house”. Many Kerelaw staff attended training provided by SIRCC, which was set up in 2000. Latterly, staff from Kerelaw were accessing training at all levels through SIRCC. SIRCC’s aim is:

to ensure that residential child care staff throughout Scotland have access to the skills and knowledge they require to meet the needs of the children and young people in their care.

10.52 As noted at paragraph 10.34, a Training Manager was seconded to Kerelaw in 2002 to draw up a training strategy and a training plan based on needs. The Training Manager was expected to provide and commission training, but not to have an oversight of the SVQ programme, in relation to which there appear to have been some concerns about the quality of assessment. This was a time-limited post for 2 years, although the individual concerned left after 11 months and the post was filled on a temporary basis thereafter.

10.53 The Principal’s report for 2002 suggested that over 60% of staff had completed or were undertaking the SVQ 3, and just over a quarter had completed, were pursuing, or were due to start the HNC. Of the 7 unit managers, 3 were holders of the Dip SW, 1 had SVQ3/HNC, 1 held a Certificate in Social Studies, 1 was working towards SVQ4 and 1 towards SVQ4/Dip SW. A note from the Training Manager in April 2003 recorded that 30 care workers were still without SVQ3/HNC and that 37 needed to top up SVQ3 with HNC or complete SVQ4.

Physical restraint

10.54 In Chapter 8 we described the introduction of TCI, and considered it in the context of the abuse which took place at Kerelaw after 1996. We heard from a number of staff who remembered the introduction of TCI training by Strathclyde Region. Some suggested that, on reflection, it had not been promoted as a holistic method of working. A manager, who had not worked in Kerelaw at that point, talked to us about the impact of TCI on the residential child care sector in general. He suggested that the reason TCI took on such significance was that it was the first training of any kind offered to residential staff in Strathclyde. This, combined with a focus on restraint, rather than the wider purpose of TCI, may well have encouraged some staff to believe that a “safe” way to control young people was further up the skills agenda than training in more child-centred competences. In the view of Brian Corby¹⁹ (quoted in Crimmens and Pitts 2000) a key lesson from inquiries is the need to ensure that:

¹⁹ Corby, B *The Impact of Public Inquiries on Perceptions of Residential Child Care* in Eds. Crimmens, D & Pitts, J *Positive Residential Practice: Learning the Lessons of the 1990s* (2000) Russell House Publishing

...training is broad-based and focused on the needs of children rather than on non-abusive ways of controlling them.

10.55 A report on staff training in July 2003 stated that the 1-day TCI refresher course run at Kerelaw was inadequate to update staff who had been trained more than a year earlier. It noted that as the TCI system had been considerably updated and amended in recent years (see paragraphs 8.32 and 8.33), it was important that staff were refamiliarised with it. In particular it recorded that during refresher training some staff were still referring to outdated TCI handbooks and holds which were no longer used. It was proposed that new handbooks be issued to all staff, including teaching staff, from the “ample supply in the storeroom”, and that the two-day refresher course designed for use in other Council residential units should be used for all future updates, which should be carried out annually.

Impact of training

10.56 Many staff told the Inquiry they had little in the way of formal induction. They were simply told to shadow another worker to learn the ropes. There can be few surer ways to perpetuate an existing culture. When introductory training was offered through the “Signpost” course and subsequently the “Introduction to residential child care” course through SIRCC, it seems some experienced staff resented the expectation that they would complete these courses. The Inquiry also picked up a view among some staff that they had little to learn from “outsiders” who in their opinion did not understand residential child care.

10.57 But by no means all staff took such a position. Many staff welcomed training and valued the opportunities to improve their knowledge base and their practice. Some staff told the Inquiry about how much they had learned on training courses and how their eyes had been opened to new ways of approaching their job. They were able to refer to specific situations where they had used their training to make a difference to their care of children. However, how learning from training was shared with colleagues in the workplace was reported as another area for attention.

10.58 Some staff talked to the Inquiry with pride about the introduction of programmes in the Secure Unit and the opportunity this offered them to learn new skills which they were expected to apply immediately in work with young people. They described this as exciting and rewarding. On the other hand, some staff were critical of programmes and felt it was not the right approach to take in Kerelaw. These differences were evident at different levels, including among senior managers and visiting specialists. This lack of a shared strategic vision or shared theoretical perspective is regrettable, as it will have led to inconsistencies in approach and uncertainties among staff.

10.59 As we noted at paragraphs 9.54-9.60, there were deficiencies in supervision. Supervision provides an opportunity for a manager to develop an employee’s ability to generalise learning and increase knowledge about how he or she learns. It also allows the manager to assess the worker’s training and development needs and how they can be met. Deficiencies in the frequency and quality of supervision and in the evaluation of the impact of training on practice may partly explain why, although a substantial proportion of staff achieved qualifications, this did not lead to the kind of shift towards a more child-centred culture which might have enabled Kerelaw better to deal with the challenges it increasingly faced.

10.60 The Kerelaw experience is a reminder that gaining a qualification, while highly desirable, will not necessarily bring about change in the individual or in the organisation. A qualification is no guarantee that the holder has the attitudes or values needed for a particular role. If training is not accompanied by reflection on, and evaluation of, one's own attitudes and behaviours, or is not positioned within a shared vision of what the organisation is trying to achieve, its impact may be limited. It is disturbing that at Kerelaw training was not so positioned, and therefore did not deliver the practical and professional benefits which should have been expected.

Conclusion

10.61 There was little by way of shared values and clear vision at Kerelaw and limited capacity for change. With 4 Principals in 8 years - two of them in a temporary capacity - regular disruption in the SMT, and senior level changes in a rather distant Social Work HQ, it is not surprising that a programme of change and improvement around a common vision of the direction of travel for Kerelaw was not achieved. Some senior people saw the need to challenge the prevailing culture and there were attempts at change, but they either failed to take hold or faded away. One particular opportunity to bring about change was lost in the management churn. The potential of training was never fully realised because it was not positioned within a clear vision of the kind of organisation Kerelaw should have been aspiring to be.

11. INSPECTION

11.1 We recorded at paragraphs 4.29 and 4.30 that a number of different bodies were responsible for inspecting Kerelaw School and Secure Unit from 1996 until its closure in 2006. In addition there were significant changes in legislation on regulation and inspection during the period, including those deriving from the (Regulation of Care (Scotland) Act 2001).

Inspections between 1996 and 2006

11.2 North Ayrshire Council carried out yearly inspections of Kerelaw Open School until 2002, when it handed this over to the newly established Care Commission. The Care Commission was expected to carry out one announced and one unannounced inspection each year, and in February 2003 it carried out its first full announced inspection of Kerelaw.

11.3 There were inspections by HMIE in 1979 and 1984 focusing on educational provision, but, as stated in the HMIE letter of 21 September 2007, to the Minister for Children and Early Years, there are no records of the Open School having been inspected by HMIE between 1984 and 2001. In 2001 HMIE carried out an abbreviated inspection of the Open School as part of a national sample of provision for pupils with special educational needs. In November 2003 HMIE and the Care Commission carried out their first integrated inspection as part of their new programme for residential schools.

11.4 The Secure Unit continued to be subject to three-yearly inspections for approval purposes. Inspections of the Secure Unit took place in 1995, 2000, 2002 and 2003 led by SWSI and including a medical professional from the SEHD. HMIE were obliged to inspect the education provision for approval purposes and they did this separately from SWSI and SEHD in 1995 and 1999. In 2002 SWSI and HMIE simultaneously inspected the Secure Unit. This inspection was not joint or integrated. In February 2003 SWSI, HMIE and the Care Commission carried out the first integrated inspection of the Secure Unit. That integrated inspection was the last one SWSI and SEHD were involved in before responsibility for inspecting secure care services passed to the Care Commission.

11.5 Correspondence in 1998 between Glasgow City Council and the Scottish Office highlights some problems with the inspection programme for the Secure Unit. Although SWSI and HMIE were carrying out the three yearly inspections to satisfy the approval process, SWSI suggested to Glasgow that local authority inspection units should also be inspecting twice yearly. After some debate about whether it should be Glasgow or North Ayrshire Registration and Inspection Unit, North Ayrshire was asked to do it.

11.6 In August 2004 the Care Commission and HMIE undertook a joint inspection of both the Open School and the Secure Unit. This inspection led to a very negative report and resulted in the Care Commission issuing an Improvement Notice in October 2004 in respect of the Open School and a Condition Notice in respect of both the Open School and the Secure Unit. The Council decided to close the Open School and did so at the end of the year. HMIE and the Care Commission continued to inspect the Secure Unit until it closed in March 2006.

11.7 The Inquiry had access to HMIE, SWSI, North Ayrshire Council and Care Commission inspection reports since 1996 as well as a number of background files, inspection notes, correspondence and action plans. Changes in the inspection process over

time are reflected in the various reports. This complicates attempts to identify improvements or otherwise over time. The various agencies took different approaches and used different quality standards. There was no formal integration of inspections until 2003 following the setting up of the Care Commission. Inspections of the Open School in particular highlighted a number of problems and concerns over the years, some more than once. These problems and concerns led to recommendations for action. Some were acted on, others were not, and there was little evidence of sustained, systematic follow-through by local or external managers in a number of important respects.

11.8 It appears that very limited information from their annual inspections was passed on by North Ayrshire Council to the newly established Care Commission in 2002. This meant that the Care Commission was not in a position to follow up a number of significant issues. In addition North Ayrshire Council's practice of inspecting the Open School and the Secure Unit in alternate years led to Kerelaw as a whole being subject to less inspection than other residential schools.

Concerns raised in inspections

11.9 A number of concerns were raised in inspection reports over the years with little progress being identified. These related to:

- Staffing: not enough staff, not enough qualified staff, many staff on temporary contracts, initially as a result of the freeze on recruitment to permanent posts imposed by Glasgow City Council immediately following local government reorganisation. Contractual issues were regularly identified by North Ayrshire Council until resolved in 2000. The need for more staff, recognised by Kerelaw management, but only partially responded to by Glasgow City Council, was also a recurrent theme.
- Supervision: lack of formal supervision, or inconsistent supervision, which we have discussed in Chapter 9.
- Fabric of the building: damaged toilets were a particular source of criticism in the inspections undertaken by North Ayrshire Council, and although improvements were noted, and some attempts were made to brighten up and redecorate living units, there is a theme of unsuitable and decaying accommodation.
- Privacy and dignity: linked with this were regular references to poor toilet, shower and bathing facilities, with broken fittings and doors which did not lock. Although some progress was noted over time, these basic living conditions were not improved quickly enough.
- Training: although some improvements were noted over time there were throughout issues about access and record keeping, and about refresher training in TCI, which was not kept up to date, as we have noted in Chapters 8 and 10.
- Complaints procedure: a poor, ineffective complaints process and lack of evidence of feedback to young people were a theme in several reports. This should have been a warning sign, but was not followed through.
- Private access to a phone: although the lack of this was noted on a number of occasions, this was still not available in all units. This is crucial to safeguarding, although we recognise there may need to be limits as some calls may have to be monitored; but the risks should be assessed on an individual basis.

11.10 File notes suggest that some inspectors had concerns which did not always find their way into published reports. This may have been because they could not always be checked and corroborated. An internal memo following the HMIE inspection of the Secure Unit in September 1999, which focused on the curriculum and made a number of criticisms of leadership and staff development, described the inspection as a “profoundly depressing experience” and said that education had risked being judged unsatisfactory, but for some committed and effective teachers. There was said to be an urgent need for inspection of residential care and that it would be important to alert SWSI. There were references also to a “general air of unrest” in the Unit which were subsequently not included in the report.

11.11 The Inquiry found no written evidence that concerns expressed by inspectors to one another in the course of inspections were consistently addressed in feedback to the Council, although we were told that “soft” information would usually be reported. We also saw internal Care Commission briefing material for the inspection carried out jointly with HMIE in August 2004. This listed a catalogue of perceived failings at Kerelaw which seemed to have been developing over some time and which were in the Inquiry’s view valid. However, these had not been exposed in the report of the integrated inspection carried out by the Care Commission and HMIE in November 2003, because, we understand, the authors felt there was insufficient “hard” corroborated evidence to include them. We return to this “soft information” at paragraphs 14.4 and 14.5.

Lack of overview

11.12 A significant contributory factor in the continuing deficiencies at Kerelaw over many years was the lack of any person or body having the whole picture. The Open School and the Secure Unit appeared to function as two separate institutions, a situation exacerbated by the changes in management introduced by the then Principal in 1999 (see paragraph 10.21), although there is evidence that, following the management changes referred to above, there were improvements in secure care. They were inspected as separate entities despite having one overall manager in the person of the Principal. The reason for this is that legislation, both previously and currently, required them to be separately registered and inspected.

11.13 Relationships between staff in the Secure Unit and the Open School were described as tense at times, but differences between the two parts of Kerelaw were not the only divide. Relationships between education and care staff were also described in inspection reports at times as poor. This picture may be mixed, however, as other references describe these relationships as positive, or at least as improving between inspections. There is some evidence in reports of strained relationships between care staff working in the units and the senior managers. Tensions were also evident between the managers in the school and their external managers in Glasgow.

First integrated inspection

11.14 In November 2003 the first integrated inspection of the Open School was carried out by the Care Commission and HMIE as part of a new programme of integrated inspections of residential schools. The inspection was, as previously noted, led by the Care Commission, but as it was an integrated inspection, it was collated and edited by HMIE in accordance with the HMIE and Care Commission protocol. This report was published in April 2004. Of the 5 recommendations for action 3 referred directly to education provision, one to the management and organisation of the school as a whole and one to residential accommodation.

11.15 Despite the weaknesses highlighted in the report, which we have described at paragraph 10.39, and although as we have noted, the Head of Education in the Open School raised concerns with the external manager, this report appears to have been regarded by some senior managers at Kerelaw as not unsatisfactory so far as care and child protection were concerned. The inspection did, however, result in requirements that the recruitment of care staff should be carried out timeously to improve the safety of young people, and that the Principal should improve the consistency of management in the residential units to ensure young people's needs were being met.

11.16 The report noted concerns relating to basic personal care. For example, in some units bathrooms and shower rooms did not provide enough privacy for young people, an issue raised on more than one occasion in previous reports. Also, residential units did not have security systems in place for visitors. Yet again staffing levels in the units were considered to be inadequate. This report referred to a number of areas where the recommendations of the previous HMIE inspection had not been implemented. For example, the school did not yet have a suitable management structure to support educational developments there, and inspectors were sufficiently concerned to attach the action list from the previous HMIE inspection with a note on what progress had been made.

Lack of follow-up

11.17 Contrary to the views of some Kerelaw managers who have suggested that inspection reports were positive over the years from 1996, a number of serious deficiencies in basic personal care were being picked up and reported on. This included some highlighted in the *Children's Safeguards Review* (1997), such as the handling of complaints and staff supervision.

11.18 There are various reasons why these issues were not systematically followed up.

- External managers were not always actively involved in this process. They did not always attend the oral feedback meetings. They did not take an active role in making sure that recommendations were implemented. Sometimes they disagreed with them.
- Internal managers did not always take inspection seriously. On at least one occasion, attempts were made to refuse inspectors entry to the school.
- Inspection agencies did not always pursue the resulting action plans.
- Prior to 2003, Kerelaw was not inspected as often as it should have been, resulting in lengthy gaps between inspections and consequent difficulties in tracking progress.
- The inspection regime changed over the years and the transitions lacked handover or overlap.
- Prior to 2002 the inspection regime did not have regulatory powers over local authority services.
- There was fragmentation of inspection, with up to 4 different agencies involved at a time.

And no-one was pulling all the information from inspections together. This was not happening within Kerelaw, Glasgow City Council or indeed in the inspection agencies until

2003, from which year there was a joint inspection process by the Care Commission and HMIE, involving SWSI as appropriate.

Inspections did not pick up abuse

11.19 Young people are unlikely to confide in inspectors that they are suffering abuse. They will often not tell anyone while they remain in the placement and they are most likely to confide in someone they know well and with whom they have an ongoing relationship. However, child abuse is not only uncovered when a young person is able to tell an adult about it. Adults working with children need to be aware of the signs and be assertive in seeking out explanations. Inspections need to look in detail at the operation of the mechanisms in place to protect children and young people. The complaints procedure would be key here, as would fully trained and well-supervised staff. Hazards should also be identified: for example, lone working, staff working excessive hours and poorly defined boundaries between staff and young people. As we have noted, warning signs had been present at Kerelaw over the years and were being identified, but no-one in the management chain seemed to take a rounded view or took ownership of following them up.

The Care Commission's response to the Glasgow Report

11.20 The Care Commission in its report for the Minister for Children and Early Years suggested that Glasgow City Council did not give enough attention to inspection reports and requirements or recommendations. It also noted that the service did not have robust self-assessment and performance management systems in place. It pointed out that the inspection regime prior to 2002 did not have regulatory powers over local authority services and considered this to have been a weakness in that system. It went on to say that regrettably not all service providers respond fully and timeously to recommendations or requirements. As a result, the Care Commission does have to take formal legal enforcement action to secure the required improvements. It noted that in 2006-07 it took enforcement action against 3 out of 35 residential schools/secure services, or 9%. It pointed out that this was a high level of enforcement when compared with other types of services regulated by the Care Commission and indicated that the internal and external management of these services needed to improve. During the same period, the corresponding figure for levels of enforcement for all regulated services was just 1%.

11.21 In the Care Commission report *The Quality of Care Services in Scotland (2007 – information from inspections to April 2006)*, it noted that there were significant concerns in more than 1 in 3 special residential schools. These concerns, all of which have resonance with weaknesses the Inquiry identified at Kerelaw, related to:

- the care and welfare of pupils
- risk management
- lack of security in accommodation
- insufficiently robust child protection arrangements
- inadequate care planning for young people
- lack of continuity between care and education
- a lack of good leadership on the part of some services

Next steps

11.22 In March 2008 the Care Commission published *Protecting Children and Young People in Residential Care: Are We Doing Enough?* Because of the number of serious allegations of past mistreatment in residential care and the concerns noted above, the Care Commission set out to check on the safeguards for young people and to encourage better practice in child protection. The report looked at 3 important areas of practice in residential care of young people: protecting children; planning for their care; and using physical restraint.

11.23 The report gathered together what the Care Commission had learned from their regulation of the quality of practice in each of the above 3 areas. Although inspections found a number of services using good practice, over 50% of services needed to improve aspects of their practice in one or more of these areas. The report made the following recommendations:

- Local authority staff responsible for placing young people in residential care services and care service staff need to make better assessments of young people's needs before they are placed in residential services, to ensure services are able to deal with challenging behaviour without excessive use of restraint.
- Care services need to consider and respond to the detailed recommendations in the report to improve practice in child protection, care planning and the use of physical restraint.
- The Scottish Government, COSLA, appropriate professional organisations, service providers and the Care Commission should work together to promote the use of a standardised system for recording when physical restraint is used and to consider the merits of introducing a national accreditation system for training in de-escalation (calming situations down) and the use of physical restraint.

11.24 On the basis of the Inquiry's findings, we support those recommendations.

Improving inspection of residential schools

11.25 In September 2008 the Care Commission issued supplementary guidance on inspection of residential care for children. This followed a review of inspection methodology and management arrangements for regulating special schools and secure services, and took account of the responses from HMIE and SWIA to the Minister for Children and Early Years in relation to the abuse at Kerelaw School and Secure Unit. In addition they took account of the findings from *A review of residential services for young people with harmful sexual behaviour* (2007)²⁰.

11.26 This prompted a more robust approach to inspections, incorporating greater collaboration with SWIA and HMIE. The Commission reviewed and strengthened their joint inspection approach with HMIE and the Inquiry was told that they were focusing inspections on key processes designed to examine the quality of outcomes for young people. In April 2008 the Commission introduced grading for all inspections, supported by requiring services to produce robust self-evaluation, involving young people, their carers and other relevant stakeholders such as placing social workers and independent advocates. Included in the

²⁰ *A review of residential services for young people with harmful sexual behaviour*. SWIA, the Care Commission, HMIE (2007)

revised inspection process is the “case tracking” model that specifically focuses on the young person’s needs being met, taking account of inputs and how these impact on positive outcomes.

11.27 It is too early to assess the impact of this new methodology. However, it does represent a more holistic approach to inspecting the quality of service being offered to children and young people in residential care, and we welcome and support that.

Conclusion

11.28 Inspection did not stimulate change at Kerelaw, partly because of insufficient coordination and overview, and partly due to lack of proper follow-up by internal and external management. Inspections resulted in mixed reports over the years, with good points and progress noted, alongside consistent concerns around staffing levels, the state of the buildings, lack of supervision, poor record-keeping, particularly in relation to complaints, and care staff-education staff interactions. It is clear to the Inquiry that inspection alone cannot be relied upon to bring about change and improvement, which can only be achieved through appropriate follow-up and management action.

12. THE CHILD AT THE CENTRE

Children's Rights

12.1 The Inquiry considered what life was like on a day-to-day basis for young people at Kerelaw and the extent to which those responsible for their care exercised their duties appropriately and placed the needs, welfare and rights of children at the centre. In 1997 Kerelaw's statement of objectives noted:

Rights are now viewed as an everyday concern for staff and residents alike. This has been brought about through training and open access to local authority's rights workers and Who Cares? Negotiation, support, responsibility, mediation and active listening are central to this issue and at every level there are opportunities to voice concerns.

12.2 A number of former staff told the Inquiry that Kerelaw encouraged CROs and other advocacy staff to visit children placed by their authorities. They appeared to recognise the importance of such services in safeguarding children in their care. However, inspections of the Open School in 1999 and 2000 by North Ayrshire Council reported that:

information regarding external advocacy services and children's rights was not available throughout the units and young people displayed a lack of awareness about how to access this information.

and:

inconsistency regarding the display of information about children's rights across the school.....Some young people seemed to have no access to their local authority Children's Rights Officer.

12.3 The Inquiry interviewed a number of CROs who had worked with children placed at Kerelaw. We also interviewed "Who Cares?" staff. All the advocacy workers we spoke to expressed concerns about Kerelaw. They were not always made welcome and sometimes were treated dismissively or ignored by staff. They also faced obstruction as they attempted to carry out their work. For example, one cited being denied access to key operating procedures without reasonable explanation. This made it difficult for advocacy workers to challenge particular working practices or advise children.

12.4 The Inquiry also heard that some staff at Kerelaw did not seem to understand the role of the CRO or indeed the centrality of children's rights in the "looked after" system. This was illustrated by the example of a member of staff asking "what about our rights?" The Inquiry was told of one CRO having to explain that children's rights were not dependent on their responsibilities, although it did not mean children had no responsibilities. We heard of one young person being told by staff that there was no point in talking to the CRO as the latter could not change anything. However, not all the staff at Kerelaw were unwelcoming to advocacy workers or resistant to embracing children's rights. In some units they were made welcome, private space was made available, and young people were encouraged and supported to approach them.

Complaints

12.5 An effective complaints system is of fundamental importance to the safeguarding of children, and the principle that young people in residential care require visible and accessible complaints procedures is widely accepted. There was a complaints procedure at Kerelaw. Documentation from 1997, 2000 and various points thereafter refer to such a procedure, and mechanisms were in place for both informal and formal complaint and allegation handling. Formal complaints leaflets appear to have been in place from at least 1997 and Glasgow City Council complaints procedures should have applied. Although all inspection reports from 1996 to 2004 acknowledge there was a procedure in place, various issues were raised as to how this was working in practice.

12.6 The Inquiry heard mixed accounts of the complaints procedure from both ex-staff and ex-residents. Some said it was well-used and effective. Others said making complaints was discouraged, the process was inconsistent and too slow, and outcomes were poorly communicated. Inconsistency in the way complaints were dealt with from one unit to another is evident in inspection reports. Generally, over the years, young people told inspectors they were aware of their right to complain and the procedure they should follow. However, inspectors noted that records of complaints and their outcomes were not always as detailed as they should have been and young people did not always receive written feedback. Responses and outcomes to some complaints were extremely brief and at times barely legible. Inadequate records of feedback raised questions about the effectiveness of the complaints system.

12.7 Most former staff who gave evidence to the Inquiry were aware, as they should have been, of the complaints procedure. Some elements appear to have been well understood. Some ex-staff talked about supporting young people to write complaints as they recognised that this was important in terms of safeguarding and promoting children's rights. Others appear to have considered it a matter of operational requirement rather than good practice. Staff attitudes to complaints were raised in two inspection reports. In one there was concern that young people were discouraged from submitting complaints because of a belief that these would not be treated seriously due to the "jokey" stance of the staff. In another report inspectors noted that complaints in one unit were treated in a minimalist fashion.

12.8 Access to complaints forms was also inconsistent. The Inquiry heard that it was standard practice for complaints paperwork to be distributed only by a duty manager. This meant that children could not raise issues anonymously or choose whom best to complain to. There were many pressures on young people not to make complaints. We were told of complaints often being withdrawn by young people. The Inquiry saw a form which had been drawn up for this purpose. Sometimes there would be a genuine change of mind, perhaps after the young person had reflected on the issue. However, in one well documented case we heard of a complaint being withdrawn because of peer pressure as a promised outing had allegedly been cancelled because staff had to attend fact-finding interviews. Peer pressure was a common disincentive. In the opinion of one external advocate, who had strong views:

The internal complaints procedure at Kerelaw was wholly inadequate. Complaints were not acknowledged in writing and young people did not receive responses verbally or in writing.young people were intimidated by staff (and other young people) when they did make complaints and some

were later withdrawn as a result.....young people feared intimidation and reprisals so much that the whole complaints procedure was undermined.

12.9 The Inquiry concluded that some staff and young people had little confidence in the complaints system. One young person interviewed by Council investigators encapsulated a prevalent view that:

...there was no point in complaining as nothing was done...

while another was more specific:

..... he had completed a complaints form several times about being hurt in restraints and passed them to his unit manager ... he had not received any acknowledgement of his complaints. No one had spoken to him about his complaints, nothing had been done.

12.10 Kerelaw managers stated in evidence that they were told to do different things by Glasgow City Council at different points in time, but maintained that they always passed allegations outside the school, and often arranged for joint investigations to be carried out with external placing authority representatives. There is documentary evidence to support that: some complaints and allegations did make it out of Kerelaw, but by no means all. When they did, rights workers, parents or in some cases fieldwork staff were generally instrumental in ensuring they were followed up.

12.11 We are aware of two local authorities raising significant concerns about the manner in which allegations of mistreatment were handled by both Kerelaw and the Council over a number of years. These allegations included emotional, verbal and physical abuse as well as concern about how practices like strip searching, single separation and restraint were carried out. A number of investigations were conducted involving external fact-finders. However, the Inquiry is aware of one occasion where the Principal refused to cooperate in a joint investigation because he did not agree with the choice of investigator and insisted the individual was replaced. The Head of Service agreed to this and appointed a different fact-finder.

12.12 The Inquiry read documents and spoke to staff from a placing authority which had removed children from Kerelaw following child protection investigations in 2000 and 2002. The Director of Social Work of this authority followed up with senior managers in Glasgow City Council and assumed incorrectly that the authority's concerns were being followed through at the highest level.

12.13 In 2001, Glasgow City Council implemented new procedures for complaints and allegations entitled *Complaints and Allegations - Keeping Children and Young People Safe*. This followed a review of the Council's complaints-handling practice in line with the findings of the Edinburgh Inquiry in 1999 and the Kent Report of 1997. The Waterhouse Report²¹ in 2000 had also recommended the vigorous promotion by local authorities to children and staff of its complaints procedures for looked after children.

²¹ Waterhouse, R *The Report of the Tribunal of Inquiry into the Abuse of Children in Care: Lost in Care* (2000)

12.14 *Keeping Young People Safe* defined separately complaints (expressions of dissatisfaction about services) and allegations (concerns raised about possible abuse or harm) and set out different responses: a standard complaints procedure route and a child protection route. It made a distinction between informal and formal complaints. It emphasised the value of trying to achieve resolution at as early a stage as possible, and provided for informal complaints to be addressed at a local level with negotiation and dialogue aimed at securing resolution without the need to invoke formal mechanisms. Within the informal route the young person was able to choose to formalise his or her complaint if he or she was not satisfied with the response.

12.15 The procedures included standard forms of paperwork covering among other things provision of information to young people and residential staff. Timescales for investigation, providing feedback and appeals mechanisms were set down and there was provision for monitoring complaints and allegations. The Keeper of the Child Protection Register in the Council was charged with responsibility for recording all complaints and allegations on a central log and was required to report to the Head of Children and Families and Criminal Justice every 4 weeks, and to the Child Protection Committee on an annual basis.

12.16 Even after the 2001 procedures were distributed some ambiguity remained as to what constituted a complaint. Some senior staff at Kerelaw refused to acknowledge a complaint unless it had been written down on paper and signed off by a resident. We were told that on one occasion external fact-finders arrived at Kerelaw to investigate an oral allegation of mistreatment, and were sent away on the grounds that the allegation was not recognised as a valid, recorded complaint. The Inquiry heard from advocacy workers that much perseverance and determination were required to follow up on complaints and allegations made by young people. Many people who gave evidence to the Inquiry said that the default position within Kerelaw was that there was no case to answer.

12.17 Kerelaw was excluded from the complaints monitoring and recording arrangements introduced within the 2001 procedures for other Glasgow units. It operated its own separate system for recording complaints and allegations and relied on the external manager to provide oversight and monitoring. The Inquiry was unable to locate the relevant logs. The requirements placed on the Keeper of the Child Protection Register in the Council to record all complaints centrally, to report to the Head of Service and to the Child Protection Committee did not include Kerelaw. The new arrangements included the introduction into residential units of boxes into which complaints could be posted. The boxes would be emptied by an administrator from outside the unit. Kerelaw apparently did not accept the boxes and it seems that although their introduction was supported by external management, the matter was not pressed or, it seems, implemented until 2004.

12.18 The Inquiry acknowledges that even those who had negative comments to make about aspects of Kerelaw's approach accepted that some staff and systems worked for some children on some occasions. Some complaints and allegations were investigated and recorded appropriately. The outcomes in such instances may well have been beneficial for children and for developing professional practices. As we have noted, some staff supported children in expressing themselves and complaining either formally or informally. Such staff made constructive efforts to respond to children's concerns speedily and in a manner which offered resolution without the need for formalisation.

12.19 In 2002 SWSI, in its follow-up inspection of the Secure Unit, recommended that the complaints procedures, which were correctly those of the managing authority, needed to reflect specific arrangements at Kerelaw. This was recorded as having been achieved in the November 2003 integrated inspection, although it was noted that Kerelaw still needed to set these procedures out clearly in the information pack supplied to placing authorities. The Care Commission inspection reports of 2003 and 2004 note that Kerelaw was not displaying the details nor including them as part of the complaints procedure, and the final integrated inspection of the Open School in 2004 noted that the complaints procedure did not meet regulatory requirements.

Admission arrangements

12.20 Although there were procedures for planned admissions to Kerelaw, we heard from a number of different sources that many, and at times most, admissions were on an emergency basis. We read correspondence and minutes of meetings which confirm that emergency admission was the most typical route. In 1997, 40% of all admissions were made on that basis. Pre-placement meetings occurred for some young people, but we heard about children often being dropped off by social workers, the police or the standby service at a point of crisis. High numbers of emergency, rather than planned admissions, can often have a detrimental effect on the care of a group of young people as there is no opportunity to ensure the mix is appropriate. Children arriving on an unplanned basis, often in crisis and sometimes in the middle of the night, is unsettling for those already in placement.

12.21 A secure screening group met weekly in Glasgow to prioritise admissions to secure care. A central prioritisation group met to allocate placements within residential schools, and would often ratify admission decisions in retrospect. Kerelaw managers were directly involved in both processes. Fieldworkers and residential care staff told the Inquiry that the process did not facilitate the matching of placements to children's needs. Kerelaw was often used because it had more capacity than other establishments, and Glasgow City Council as managing authority was able to direct admissions to a greater extent.

12.22 Some suggested that Kerelaw, as a local authority resource, was not in a position to be as selective as other establishments and took more than its fair share of inappropriate admissions. The lack of alternative specialist resources, in particular for young people with mental health problems and learning difficulties, also led to many inappropriate placements. Expectations of quality care and positive outcomes were not high, but Kerelaw fulfilled a purpose. There was a frequently reported view that Kerelaw was no more than a dumping ground for young people who had particular problems or who had "failed" in other placements. Most Council managers who gave evidence to the Inquiry conceded that Kerelaw was not ideal and some said that it functioned as a "safety valve in a dysfunctional system".

12.23 We heard from different people and read evidence suggesting that there were also occasions when children were accepted on a respite basis. At times this involved their sleeping in beds only temporarily empty due to other children being on home leave. This was highly inappropriate and communicated a lack of care to both the child on leave and the child on respite.

12.24 The Inquiry was told that the age profile of the young people in Kerelaw increased over the years, with many young people over the age of 16 placed there. Minutes of screening groups we read indicated that a shortage of supported aftercare placements meant that those

who had started at Kerelaw at 14 or 15 had to remain there much longer than had been planned. Children who are brought up at home with their families are rarely ready to leave home at 16, and keeping them within the children's system until they are at least 18 can be good practice. However, the right support needs to be in place to prepare them for moving on. This was one of the challenges in caring for a group of young people whose age range was steadily increasing.

12.25 At times, Kerelaw was able to offer dedicated staff to this group to help them prepare for the future. In the mid-1990s the Deputy Head (Open School) designated unused accommodation for independent living as a base for preparing young people over the age of 16 for leaving Kerelaw. This was not resourced properly and relied on staff working extra hours to keep it operational. Some of those who spoke to the Inquiry praised the initiative as innovative and necessary. Others considered that the arrangements were badly thought out and poorly managed. As we noted at paragraph 10.20, the facility was ended in early 1999, following concerns about a budget overspend, although the Deputy Head (Open School) tried unsuccessfully, including through a direct intervention with the Depute Director of Social Work, to keep the initiative alive.

12.26 At other times, young people approaching adulthood were largely left to their own devices and little in the way of effective throughcare work appears to have taken place. There is some evidence that young people were discharged in an emergency when their Kerelaw placement broke down. Thus both the routes in and out of Kerelaw for young people were often when they were experiencing significant difficulties. This is bound to have had a negative impact on the atmosphere and stability of the care setting.

Needs Assessment, Care Planning, Interventions and Review

12.27 The Inquiry considered the arrangements for assessment and care planning for children placed in Kerelaw. We read the available fieldwork and residential files for a sample of 30 young people who had been placed at Kerelaw between 1996 and 2006. We found a mixed picture. With so many young people placed on an emergency basis, social workers had little opportunity for care planning prior to admission. Glasgow City Council fieldworkers had significant caseloads. One former senior child care manager said that in the early 2000s only about 30% of looked after children in Glasgow had care plans, and that some child care fieldwork teams were running with 50% vacancies. This is not surprising given the severe shortage of qualified social workers which the Council was experiencing at the time, and it meant that many children in care did not have an allocated worker. The Inquiry is concerned at the impact this must have had on effective care planning, safeguarding and review for children in care.

The role of fieldworkers

12.28 Fieldworkers should have had a central role in ensuring that placements in Kerelaw were appropriate, planned and purposeful. Glasgow City Council set out responsibilities in terms of care planning and review procedures in 2002 in response to the *Looking after Children In Scotland, Good Parenting Good Outcomes* material. These procedures superseded review procedures established by Strathclyde Region and amended in 1990 and 1995. In 2004 the Council updated the 2002 procedures.

12.29 From our file sample we concluded that recording practices varied considerably in scope, quality and accuracy. We were particularly concerned about the lack of attention to detail evidenced for example by different spellings of children's names and different dates of birth for the same child. This lack of quality control may lead to problems retrieving data in the future. The Inquiry found this careless approach to recording important information about children under the care of the Council disconcerting, and would be concerned if the lack of attention it implied had been replicated in direct engagement with young people. In some case files the recording was so poor it was not possible to establish the frequency of contact between the worker and the child. Nor was it always clear what work was being carried out.

12.30 We were able to draw some conclusions about the progress of care plans from reports provided for Children's Hearing and Looked After Children reviews. However, we noted that there was rarely a complete set of Looked After Children review paperwork. Often papers had not been tabled in advance of reviews and we assume had therefore not been discussed with the young person. We found it difficult to track progress between reviews, mainly because of the similarity of information presented on each occasion. We found little detail in the files of focused or specific interventions whether by fieldworkers, care staff, education staff or specialist services.

12.31 In the papers sampled, a lot of care planning activity seemed to be about home leave negotiations. The use of home leave was encouraged by Kerelaw. It was used as a way to help children retain contact with family and community life as well as a process of developing independent living capacity. Its cancellation was used as a sanction. We saw little reference to specific needs assessment, risk assessment or planned interventions, and the impression gained was of action planning being more about sustaining the Kerelaw placement, rather than addressing particular issues or behaviours which had contributed to the decision to accommodate the young person there in the first place. The Inquiry recognises that this approach may be appropriate for some young people at key times in their placement journey, but the apparent lack of other action planning was unsatisfactory.

12.32 Fieldworkers we talked to said they would assess and draw up care plans, but because they did not have the necessarily resources, they could not deliver the plan. Day-to-day implementation of the plan was generally up to Kerelaw staff. We did see evidence of prolonged social work involvement with young people and their families prior to admission to Kerelaw. There was evidence that attempts had been made to support young people when they were in the community. Some had been supported at home or in foster care or residential care before placement at Kerelaw. Referrals to other agencies and projects for community support, group work and addiction services were evident. When a young person moved to Kerelaw, access to support services revolved round the school, and meaningful links with community services was minimal.

12.33 The Inquiry reviewed a small sample and we appreciate this may not be fully representative. However, it was clear that poor recording made it difficult to judge the appropriateness of fieldwork responses or establish the extent to which fieldworkers were able to drive care plans or follow through on safeguarding concerns. We also found unrelated files mixed in with the sampled files, which suggested that, should a young person ever wish access to his or her file in the future, he or she would be most unlikely to obtain the "misplaced" material. This is poor administrative practice and has an echo of the

unsatisfactory record-keeping which was an important deficiency identified by Tom Shaw in his report on systemic child abuse in Scotland published in 2007²²

The role of Kerelaw staff

12.34 Ex-staff from Kerelaw told us that the concept of care planning within the school was emphasised following the arrival of the new Deputy Head (Open School) in 1993. The 1997 statement of objectives clarifies the Kerelaw approach to care planning as follows:

Individual care planning is the important building block for all young people referred to Kerelaw. Planning is undertaken by the key worker in collaboration with teacher, social worker, young person and family from the first stages of pre admission, to through care planning in the final phase. The care plan is promoted through weekly planned supervision sessions between key worker and resident and monthly with the key teacher. The Child in Care Review is the appropriate forum for significant modification to the care plan and these follow the local authorities approved format

12.35 The Inquiry heard that staff welcomed this new emphasis and were involved in care planning with young people. Many recognised that as key workers they could develop good relationships with young people and make progress with care planning objectives. From our review of Kerelaw files, we found a range of proformas, care planning materials and recorded information on young people's progress. We were told that individual units developed different approaches and would adapt the forms, but that between 1999 and 2000 common care plans were introduced. However, we gained little sense of joint working between the placing social worker and Kerelaw staff. There was often no direct correlation between formal Looked After Children care plan actions and objectives, and the day-to-day personal plans and records held in the residential unit.

12.36 Specialist addiction counselling, offending behaviour programmes and cognitive skills training were offered at Kerelaw, but we saw no written evidence of this work within individual records we sampled and can therefore make no judgement on its impact. Some fieldworkers said there was very little therapeutic intervention at Kerelaw and that, despite much being said by the school about its programmes, little was evident in reality. We did not find evidence on which to judge the accuracy of such assertions.

Absconding

12.37 Absconding appears to have been a regular and routine part of life for many young people at Kerelaw. Responses to children missing from placement varied. Some staff would try to prevent young people absconding, and would sometimes search the immediate area to try to get the young person to return. On other occasions, staff would simply record the absconding, notify the police, and await the young person's return.

12.38 All of the above responses may be appropriate, depending on the circumstances. Responses to absconding have changed over time within the residential sector. The Council's *Missing from Placement Procedure* issued in 2000 and updated in 2004 differentiates

²² Shaw, T *Historical Abuse Systemic Review* The Scottish Government (2007)

between a “missing child” and a “failure to return”. The procedure acknowledges that placement staff need to exercise judgement as to response, depending on the assessed needs of and risks to the young person concerned, and his or her pattern of absconding. The procedure prescribes administrative arrangements for alerting Social Work HQ, notifying the police, the fieldworker and the child’s parents.

12.39 The Inquiry heard from a number of former staff of the challenge of assessing risk and intervening appropriately. Some former staff took the view that, on a child’s return, often late at night, and under the influence of alcohol or drugs, they had a duty to ensure the safety and wellbeing of the child. Some spoke sensitively about balancing the need to assess the risk the young person posed on return to himself or herself, and to others, with the need to ensure he or she was fed, made comfortable and brought back into the life of the unit. Conversely, we heard about punitive attitudes among night staff who saw their job as simply getting the returning absconder off to bed. This limited interpretation of their role seems not to have stretched to consideration of needs or risks, although we did hear that night staff felt overwhelmed at times having to collect absconders from distant locations, or search the grounds for absconders while maintaining sufficient presence in the units.

12.40 Some young people ran away because of incidents at the school or confrontations with staff or other residents. Absconding became a particular problem in late 2003 and early 2004, but we found little or no evidence of monitoring absconding rates across units, across shifts or across time periods to establish reasons. A significant increase in absconding in late 2003 appears to have been ascribed largely to the nature of the young people being sent to Kerelaw who, as we note at paragraphs 7.12 and 10.30, seemed by then to have become more challenging. But it is hard to escape the conclusion that there was over the years a degree of complacency on the part of the school and Glasgow City Council, and a lack of concern for what the young people involved might have been trying to say. A number of former staff told us that, with hindsight, they had asked themselves, not simply where did the young persons run to, but why did they run, and whether they were running from something that was happening at Kerelaw.

Conclusion

12.41 There were deficiencies in the way in which the interests of young people were protected at Kerelaw. Many of them were placed on an emergency basis which meant that there was often inadequate care planning prior to admission and a level of disruption and instability when they arrived. There were weaknesses in the arrangements for children who were placed in, and accepted at, Kerelaw and little joint working between placing social workers and Kerelaw staff. The rights of young people were not adequately upheld. The complaints system did not work effectively and there were pressures on young people not to make complaints at all. This important safeguarding issue was continually raised in inspection reports and was not properly followed up. The Inquiry’s conclusion is that the arrangements for children placed at Kerelaw were insufficiently child-centred, despite the kind of Mission Statement described at paragraph 4.11.

13. GLASGOW CITY COUNCIL'S STEWARDSHIP OF KERELAW

13.1 Local government reorganisation could not have come at a more unhelpful time for Kerelaw or for social work in Glasgow. Faced with the challenge of responding to major changes in legislation and regulation, senior managers in Glasgow City Council found very significant time tied up with managing the consequences of reorganisation. This included requiring staff from the former Strathclyde Region to be matched into Glasgow City Council posts in extremely difficult financial circumstances.

Financial pressures

13.2 Financial pressures were a major preoccupation for the Council. There were particular pressures on social work budgets as a result of how Glasgow's financial settlement was calculated. Balancing the budget against staff costs was a significant problem, not least because of the Council's policy of no compulsory redundancies. The Inquiry was reminded that there were poor relations between Social Work Services and the Council's management, with demonstrations in George Square and Council meetings disrupted. There was a crisis in social work staffing, with qualified social workers leaving to work for other authorities, and a general shortage of such staff lasting for some years.

13.3 The pressure on the Social Work Department from the scale of social problems which the Council faced, and still faces, was particularly acute. Discussions of budgets and restructuring were major, recurring items on the agendas of meetings in the Department and at corporate level in the Council, and took up much senior management attention. With financial problems preoccupying senior managers and the restructuring of Council services changing management responsibilities, it is unlikely that the needs of an institution 30 miles away, of which there was little understanding at the centre, would be a high priority in the first few years. As noted previously, the immediate impact on Kerelaw was a freeze on recruitment, which had later to be eased for residential units to enable them to function.

13.4 Residential accommodation is expensive, and it is clear from the records and from evidence to the Inquiry that the Council baulked at the cost of placing young people in residential care offered by other providers when this was more expensive than Kerelaw. A Best Value Review of Kerelaw, undertaken in 2000, which focused on the proposed rebuild and redevelopment based around the Secure Unit (see paragraphs 13.42-13.44), rather than the existing facility, recorded the cost of a placement in the Open School at £1,125 compared with £1,361 to £1,699 in residential facilities run by other agencies, and up to £2,900 in a close support environment. Kerelaw's Secure Unit costs were stated to be £2,093 a week compared with up to £2,749 elsewhere. The Review noted that:

Increasing the usage of the resource clearly carries a cost benefit to the Council if this is offset by a reduction in usage of more costly alternative provision in Scotland.

13.5 It recommended that as a matter of policy Glasgow City Council should increase its user share to 60%, thereby generating a saving in the cost of purchased places elsewhere, although a review of staffing agreed by committee in July 2001 proceeded on the basis of a figure of 50%. Kerelaw was both a cost and a potential source of revenue from other placing authorities, and it appears that significant priority was given to keeping Kerelaw's costs under control. At local government reorganisation in 1996, Kerelaw was organised as joint resource

among all ex-Strathclyde Regional Council user authorities, reporting through a Joint User Committee (JUC), which agreed staffing levels and budgets. In 1999 the JUC was disbanded, leaving Glasgow City Council with sole responsibility for the management of the budget and the setting of weekly rates. A former member of Kerelaw's SMT asserted that:

Glasgow was reluctant to raise fees and the related authorities were unwilling to pay more – even while complaining about the poor standard of Kerelaw.

13.6 The Council disputes that statement, but cost control was clearly important not only as good housekeeping, but also as a demonstration to other providers that it was possible to operate at a lower cost than theirs. A former external manager told us about:

...a dispute involving COSLA over residential school charges. The schools wanted to raise their fees. There was something of a stand off with Glasgow who refused to pay extra fees. Budgetary control at Kerelaw was then tightened to keep down cost and to demonstrate to other providers that residential schooling could be provided at a lower rate...this did affect Kerelaw at the time but... it was later recognised as not sustainable and investment increased...

or as it was put more bluntly by another witness:

Glasgow didn't want to use the independent sector as it was cheaper to use Kerelaw. Kerelaw's fees had been kept low to put a gun to the independent sector schools – to help keep the costs down.

13.7 Obtaining adequate resources for Kerelaw was therefore not easy for local management or for the Head of Service in the Social Work Department, where we learned there were numerous disagreements over funding priority between children and families services and community services. A review of staffing requirements by Strathclyde Regional Council in late 1994 had recommended restructuring and staffing reinforcement at Kerelaw. Staff numbers were supposed to rise from 80 to 97 at cost of nearly £300,000. Senior management was to be slimmed down, but 7 unit manager posts with some corporate responsibilities were to be created, along with 7 deputy manager posts. Night staffing was to be strengthened, with supervision added in. The Social Work Department was said to have contingency money for some of this, but the remainder was to be implemented when budgets allowed. It appears that budgets did not allow. Unit management was strengthened, but by 2001 the recommendations had still not been fully implemented. This had led to sickness and annual leave cover having to be met through overtime.

13.8 Although limited funds were provided from time to time to improve living conditions, concern about budgets was a regular feature of inspection reports, even before local government reorganisation. Following its inspection of the Secure Unit in May 1995, SWSI referred to a failure to establish an adequate budget, although an HMIE report on the Secure Unit later in the same year commented more favourably on the education resources. North Ayrshire Council's report in January 2001, following its inspection in October 2000 of the Open School, expressed concern that staffing levels were insufficient to meet the needs of young people and that there were potentially dangerous situations.

13.9 A case for additional staffing put together by the Principal in 2000 did not succeed, because planned increases in charges to pay for it were not agreed with COSLA. However, a paper reviewing staffing requirements for Kerelaw was submitted to committee at the end of July 2001. This referred to the adverse comments in Inspection reports about staffing levels and, by reference to the Waterhouse and Edinburgh Reports, to the need for extra staff to safeguard young people. It noted that a substantial increase in charges would now be required for 2001-02 to provide additional resource for Kerelaw. A number of additional care-related posts were approved and as noted at paragraph 10.35 these were successfully filled. These were welcome new resources, although two years later the Principal was again expressing concern that staff numbers were low.

External management

13.10 While the management churn at senior level within Kerelaw which we described at Chapter 10 militated against consistent leadership at a time when such leadership was becoming ever more necessary, deficiencies in internal leadership and management at Kerelaw cannot be viewed in isolation from deficiencies in external management. If vision was lacking at Kerelaw, it was no more in evidence in the Council, where a policy aspiration to reduce the use of residential accommodation for young people seemed to co-exist with a reliance on Kerelaw as a disposal of last resort for the most problematic client group.

13.11 Prior to 1996, external management of Kerelaw was provided through the District management of Strathclyde Regional Council's Social Work Department. We were told by some that the arrangements worked reasonably well, and that an external manager would regularly attend senior management meetings at Kerelaw. Others were more critical. As might be expected in relationships between a distant HQ and its field operations, there were from time to time budget issues and other points of friction, but the Inquiry was told that the external managers broadly understood Kerelaw and its needs. HQ, however, seemed largely to leave Kerelaw alone. We were told that senior people from Regional HQ in Glasgow tended to visit very infrequently.

13.12 At the transition of external management from Strathclyde Region to Glasgow City Council, Kerelaw became the responsibility of the Council's North and West District, and the District Manager became the external manager. He had a large workload and delegated responsibility for the day-to-day external management to his assistant District Manager. The latter was responsible for external management of all the residential establishments in North and West District and did not have a specific job description regarding Kerelaw. We heard in evidence that, although he had regular meetings with the acting Principal of Kerelaw, these were roughly every 6 weeks, less frequent than under the previous arrangements.

13.13 As we noted at paragraph 10.7, the external manager became acting Head of Kerelaw towards the end of 1997. Following restructuring within Glasgow City Council, formal external management responsibility then lay with the Head of Children and Families (Head of Service). She delegated day-to-day management tasks to an assistant principal officer, residential child care, who had previously worked as an assistant district manager and had extensive involvement in child care services. This was not welcomed by the individual concerned, who considered that she could not do the job justice. Kerelaw was only one component of her remit and she felt that, for legitimate personal reasons, she could not adequately undertake the on-call responsibilities or oversight of a large residential estate.

13.14 While the new external manager aimed to visit Kerelaw once every 2 to 4 weeks, in her year in post (she left Glasgow City Council in 1999), the Inquiry was told that she managed to visit all aspects of the Open School only once and the Secure Unit 3 times. She attended only one full staff meeting and participated in parts of senior management team meetings. Her early focus was said to have revolved around outstanding grievances and rumblings from certain staff. These rumblings included the concerns previously raised by the Deputy (Open School) about practice, which she believed related to allegations of physical assault of children by staff, unacceptable restraints and the way staff talked to children. However, it appears that these particular concerns were not followed up, although both the Head of Service and the Depute Director had been involved, as noted at paragraph 10.8, in consideration of the implications of fact-finding into allegations of assault by a young person placed by another authority.

13.15 With the departure of the external manager in 1999, her responsibilities fell back on the shoulders of the Head of Service, whose own position had become more stretched when the Depute Director of Social Work became Director and was not immediately replaced. This coincided with the implementation of the Children (Scotland) Act 1995 and the first round of Children's Services Plans - a substantial piece of work. In 2000 she was given the additional responsibility of Criminal Justice Services, and had to cover for the vacant Depute Director post. There were therefore few visits by the external manager to Kerelaw, although the new Principal appointed at the end of 1998 did maintain frequent and close contact with her, and there are records of exchanges between them on a number of matters, including concerns about Kerelaw expressed by external users.

13.16 Particular difficulties arose when in 2001 the Principal, having become Head of Service following the latter's promotion to Depute Director, appointed a Principal Officer with no experience of residential child care to be external manager. We were told that workload issues were the main reason for this delegation of management responsibilities, but we also heard that the Head of Service considered it unfair to the new Principal of Kerelaw to have the former Principal as his external manager.

13.17 This particular appointment was to be the source of continuing and growing resentment on the part of the management at Kerelaw. The Principal did not consider it appropriate for two main reasons: the individual's lack of relevant experience; and his junior position in pay and grading terms in relation to the Principal. To the Principal, this was a downgrading of external management. Although in time a working relationship was established, it was not helped by the external manager's role in "instructing" Kerelaw to take difficult young people from Glasgow in such numbers as to exceed the understanding, to which we have referred at paragraph 13.5, that residents from Glasgow would not exceed 50% of the available places.

13.18 In late October 2003, staff petitioned the Principal to have what they regarded as a particularly challenging young person removed from Kerelaw. This led to the external manager recording his concern with the Principal about how this young person was being managed. While in no way condoning inappropriate responses by employees to the problems they were facing at Kerelaw, the Inquiry considers that more should have been done by Glasgow City Council to support Kerelaw management in what was becoming an increasingly difficult position in 2003. The staff petition should in the Inquiry's view have been a signal that it was time for more robust senior intervention by Social Work managers.

13.19 A further problem in the relationship between Kerelaw and the Social Work Department was a familiar one - the external manager's workload, and his lack of visibility in Kerelaw. We were told that the view in the Social Work Department was that, following the work done by the previous Principal, Kerelaw was now on a solid footing, and that in consequence it took a lower priority than some other work. It is hard to imagine how much lower priority it could achieve. Initial arrangements for monthly "supervision" sessions involving the Principal appear not to have been sustained, which is perhaps not surprising, since following staff changes the external manager's responsibilities were widened to cover all Glasgow City Council children's units. He was also required to act up as Head of Service for a period in 2002.

13.20 In all cases after 1996, external managers to whom responsibility was delegated did not visit Kerelaw enough to walk round units, to speak to residents, and to see for themselves what was going on. Although comprehensive oversight of a large campus like Kerelaw would have been more difficult than for smaller units, they should have visited more frequently and spent more time there. Set against the requirements of external management contained in The Children (Scotland) Act 1995 Regulations and Guidance Volume 2, to which we have drawn attention at paragraphs 5.9 and 5.10, Glasgow City Council's external management performance failed to meet acceptable standards.

13.21 We appreciate that the size of individual workloads made the proper discharge of external management responsibilities difficult but, if Kerelaw had occupied a higher position in the Council's priority list, more care might have been taken to ensure better quality of stewardship. It was put to the Inquiry that the low priority attached to Kerelaw was due partly to its not really being seen as part of Glasgow City Council, and partly to a view that Kerelaw had on site a senior management structure sitting above what were in effect 7 units in the Open School and Secure Unit of a size comparable to small units elsewhere. That being so, it was suggested, the Principal and his senior team might be regarded as a form of external management. We were not able to establish if this kind of thinking was formally articulated. Whether it was or not, it was seriously flawed.

13.22 A further factor in the low priority given to managing Kerelaw may have been that as the plan was to redevelop Kerelaw in the light of *A Secure Remedy*, it was not worth devoting too much time and energy to it. However, we were not able to find documentary evidence to support that view, apart from a letter to HMIE noting in follow-up to an inspection report on the Secure Unit that, with redevelopment in view, there was no likelihood of resources being provided to do what HMIE recommended with regard to the curriculum (see paragraph 10.24).

13.23 The Inquiry heard evidence that the Head of Service who took up post in May 2002 maintained the arrangements for external management that he inherited, but identified a need to integrate Kerelaw into the Social Work Department's management structure. He sought to increase Finance and HR involvement in Kerelaw, and invited the Principal to attend senior team meetings. The records show that the Principal was present at a number of Children and Families/Criminal Justice Services management meetings until June 2004, although we gained the impression that the opportunity cost in terms of time involved in travelling to Glasgow for such meetings was seen as a disincentive to attendance on every occasion.

13.24 We were told by several witnesses that the Principal was resistant to closer external management although, as we noted at paragraph 10.34, in a memo in May 2002 he referred to

the need to locate Kerelaw firmly within the spectrum of child care and staff support which Glasgow offered, and suggested the re-establishment of the Kerelaw Management Group. The alternative view is that his main concern was about the grading of those identified for the external management task. Around the middle of 2002, a move to strengthen external management of Kerelaw by the appointment of an additional Residential Services Manager with experience of residential child care was effectively vetoed by the Principal, who said he had concerns about the remit for the job, which the individual concerned had been asked to draw up. We were told in evidence that she did this by reference to Glasgow City Council's own prescriptions as to the role of external managers. Following the objections of the Principal, the appointment was not pursued.

13.25 The Inquiry obtained a copy of a report dated July 2002, written by two Glasgow City Council Principal Officers who had completed a fact-finding investigation of a complaint by a member of the SMT against a senior colleague. The complaint, which was not related to the treatment of any Kerelaw resident or former resident, was upheld and disciplinary action was recommended. The purpose of the separate report, which was addressed to the Depute Director, the Head of Service, and the external manager of Kerelaw, was to raise concerns about a number of wider issues brought to investigators' attention by a variety of staff. These concerns related to the management styles and abilities of a number of managers, and to a perceived lack of clear direction and leadership from the SMT. The paper raised questions around staff recruitment, professional boundaries, attitudes, and confidentiality. It concluded that these management issues should be addressed and that action was needed. The authors sought an early meeting with those to whom the report was addressed to discuss their concerns.

13.26 We found no evidence that this report received a response or was followed up. We saw no record of any meeting having taken place although, as we noted above, the Principal began to attend senior management meetings in the Social Work Department. The Inquiry was not able to establish whether this was a response to the report or not. Although disciplinary action was taken against the subject of the original complaint (the recommended disposal was reduced by the Head of Service on appeal), the Inquiry was unable to establish whether the wider concerns expressed in the report were ever followed up.

13.27 In August 2003, as difficulties at Kerelaw grew, the Principal put forward proposals of his own for external management support. This resulted in the assignment of an Assistant Residential Services Manager with residential child care experience as an external "consultant" as described at paragraph 10.44. This assignment was made with a view to his being on site at least one day a week. We were told that some staff were puzzled by his remit as they were not used to someone outside the school being involved in management. Some unit managers were said to be suspicious, although they were not, apparently, obstructive. As provided by his remit, the new consultant attended unit managers' and some SMT meetings, and spent time in units looking at their records, which he found to be in need of improvement.

Relationships in the Social Work Department

13.28 Meanwhile, the Social Work Department had its own problems. We heard in evidence that more or less from 1996 to 2002, relationships between two successive Depute Directors with responsibility for Children and Families/Criminal Justice and senior colleagues in the Social Work Department of Glasgow City Council were difficult. These difficulties arose not

only from differences over structures, staffing and budgets, but also from differing management styles. It is on record that the Depute Director for Children and Families/Criminal Justice appointed in 2001 took out a grievance against the Council. Her charges of bullying and harassment were not upheld and she left in 2005.

13.29 From what we heard, it appears that aspects of the culture in the Social Work Department during what was a period of regular restructuring of Council Services, staff changes and budget pressures, were little better than at Kerelaw. The behaviours of some senior social work managers appear not to have been conducive to teamwork or collective problem-solving, and did not contribute to an environment in which a manager with operational problems to resolve could have exposed those to view, far less seek help. Against that background, and given the other preoccupations of senior managers in Glasgow, there will have been little incentive to probe too deeply into how an institution, some considerable distance from Glasgow, was being run.

Investigation of external management

13.30 In Spring 2005, after the closure of the Open School, an investigation into the external management of Kerelaw was ordered by the Chief Executive of the Council following concerns expressed by elected members who had begun to hear appeals by employees against dismissals. This led to a report to committee in December 2005. The report concluded that external management was handicapped because line management responsibility was discharged at an insufficiently senior level. It considered the decision by the Head of Service to delegate external management, as described at paragraph 13.16, “unusual” and the management structure put in place at that time to be “flawed”. However, the Inquiry found no evidence of the Head of Service’s decision having been challenged at Depute Director or Director level. The investigation concluded that, although there were deficiencies in external management of Kerelaw, internal management was largely responsible for the issues which came to light in 2004. It also expressed surprise that the Principal had been permitted to exercise a veto on proposals to strengthen external management in 2002. We share that surprise.

13.31 In its report to the Minister dated August 2007, Glasgow City Council conceded that from 1996 external management was not sufficiently resourced to oversee the functions and performance standards within Kerelaw and that there was limited insight into management and staff behaviours and cultures. The Inquiry regards this as an understatement. After local government reorganisation, external management of Kerelaw was increasingly neglected. Responsibility was passed around a number of individuals, some of whom did not want it. Within the Council, there seems also to have been a lack of clarity as to who had responsibility for certain issues which arose at Kerelaw. This lack of clarity was noticeable in some of the interviews with witnesses. Although there was evidence that the Head of Service in 1998 and 1999 tried to review violent incidents and follow up on complaints, external monitoring seems to have largely faded away until concerns escalated in late 2003.

13.32 While external management failed, and deserves to be criticised, its failures do not excuse internal management deficiencies at Kerelaw or relieve senior managers there of their own responsibilities. We agree that internal management - over a period of years - was largely responsible for the issues which came to light in 2004. The evidence of problems which built during 2003 and erupted in the Spring of 2004 had been there for a considerable time. Even in 2003, complaints and concerns were being considered in isolation and no one

appeared to be putting together a wider picture. There had been attempts at improvement by certain individuals, as we have seen, but they were not sustained when the individuals moved on. Managers at all levels from Kerelaw to the senior reaches of the Social Work Department must take their share of responsibility for the way in which young people in their care were let down.

Placements

13.33 We have described the arrangements for placing children at Kerelaw at paragraphs 12.20-12.26, and have noted a number of weaknesses in this aspect of Glasgow City Council's stewardship of Kerelaw and its residents.

Education at Kerelaw

13.34 Most of the former residents who gave evidence to the Inquiry related poor experiences of education at Kerelaw. Some described spending most of their time in class watching videos or colouring in. Some expressed regret that they had not achieved educationally as well at Kerelaw as they might have done at mainstream school. However, a few former residents told us they had good educational experiences and achieved qualifications, including Standard Grades. Some former residents have gone on to further education.

13.35 Some former residents talked of classes being disrupted because pupils were able to come and go as they pleased. A former teacher confirmed that this had been the case in the Secure Unit but had changed around 1999, and pupils were expected to stay in classes until the lesson was over. Former teachers to whom we spoke talked of significant challenges. For example, the shifting population of children made it difficult to teach to certificate level. Many children arrived at Kerelaw having missed a lot of schooling and teachers spent a lot of time on basic literacy and numeracy. Records from previous schools would apparently take weeks to arrive. They also noted that an older age group of 15/16 year olds presented greater educational challenges.

13.36 Former teachers highlighted a number of positive aspects of their experience at Kerelaw. They could opt to work overtime in the residential units and in that way could get to know their pupils in a different environment, which had positive effects in the classroom. Some teachers organised activities for children in the evenings, such as woodwork and cooking. Teaching staff also took young people on outdoor activities such as hill walking, which helped them develop better relationships and provided a new learning experience.

13.37 We heard that over the years Kerelaw had become more academically oriented. Some teaching staff saw this as progress but others suggested it was at the expense of more vocational opportunities. HMIE raised concerns about the structure of the curriculum a number of times over the years. For example in 1999 HMIE evaluated the structure of the curriculum in the Secure Unit as unsatisfactory. However, by February 2003 a joint inspection (HMIE, SWSI, Care Commission and SEHD) found the effectiveness of educational provision to be good.

13.38 The 2001 inspection of the Open School evaluated a number of indicators as "fair", including the structure of the curriculum, the quality of teachers' planning, the quality of pupils' learning and the effectiveness of promoted staff and senior teachers. As we described

in Chapter 10, HMIE remained involved with Glasgow City Council and Kerelaw to support them in preparing their action plan, which appeared to be problematic. Despite this support, very little progress had been made before the first integrated inspection of the Open School in 2003.

13.39 Classes were small, with a maximum of 6 young people in the Open School and 4 in the Secure Unit. Teachers faced challenging behaviour from young people on a daily basis. One teacher suggested that he spent more time managing behaviour than teaching. He described using rewards like time on the computer or a promise of free time on a Friday to keep children motivated and learning. We read minutes of education staff meetings and found them dominated by concerns about pupils' behaviour. Many of the teaching staff were trained in TCI.

13.40 We heard that recruitment of teachers posed the same difficulties as that of care staff. Teachers often started off as supply teachers and then applied for a permanent post. We heard from a senior teacher that recruitment of teachers was difficult and promotions were usually internal. Although some teachers actively chose to work at Kerelaw with children who had social, emotional and behavioural difficulties, we were told that others ended up there by chance, through the supply list. Nevertheless some came to enjoy the challenges of the setting and went on to complete specialist training, for example the Certificate in Special Educational Needs.

13.41 There were 19 teachers at Kerelaw in 2000: 1 Deputy Head Teacher, 4 Principal Teachers, 5 Senior Teachers and 9 teachers. This is a relatively small staff group, which must have made it difficult to offer a broad range of subjects to young people. The structure of education staff changed over time and by 2003 there were two Heads of Education – one for the Secure Unit and one for the Open School. The two “schools” – Open and Secure - seem to have operated quite separately.

The redevelopment of Kerelaw

13.42 As noted at paragraph 10.13, only 3 months after Glasgow City Council became responsible for Kerelaw, the then Scottish Office published *A Secure Remedy: a review of Secure Care in Scotland*. This Scotland-wide review of secure care listed a number of serious problems with the accommodation in Kerelaw's Secure Unit. It criticised among other things the building's two-storey structure, its ventilation, space shortages, and lack of adequate separation for girls. It noted that the location was over 30 miles from Glasgow and recommended that Kerelaw should be redeveloped on a site closer to Glasgow.

13.43 The Director of Social Work recommended that a new Secure Unit should not be developed in isolation from other provision and it was agreed within the Council that a redevelopment based on a new Secure Unit with “close support” but “open” units alongside would be an appropriate model. In 1997 Glasgow City Council approved the preparation of a submission for funding to the Secretary of State for Scotland. The question of how a new facility might be financed then became the subject of protracted correspondence and discussion, first with the Scottish Office, and subsequently, following Devolution in 1999, with the Scottish Executive.

13.44 Consideration then moved at what can only be described as snail's pace. Throughout the period covered by the Inquiry there was a presumption that Kerelaw would at some stage

be redeveloped. By the time the Scottish Executive agreed in 2003 to contribute to funding the rebuilding of the Secure Unit, this was going to take place on the existing site in Ayrshire. An Implementation Group was set up in 2003 to take the project forward and met regularly, right up to the eve of the announcement in 2004 that Kerelaw would close. It may be that the redevelopment of Kerelaw would have proved a stimulus to cultural change, although the focus was on the Secure Unit. However, since there seemed to be no shared view of the future in the SMT, it is hard to see how change would have been achieved even in a new, redeveloped, Kerelaw without changes in the establishment's senior management, a willingness by senior Social Work managers to push for a new approach, and a closer relationship between the institution's managers and external managers in Glasgow.

Lessons from other Inquiries

13.45 There have been two major inquiries into abuse in residential child care in Scotland: *Edinburgh's Children: The Report of the Edinburgh Inquiry into Abuse and Protection of Children in Care* – published in 1999; and the *Fife Council Independent Inquiry* following the conviction of David Logan Murphy for the sexual abuse of children – published in 2002.

13.46 The Edinburgh Inquiry made 135 recommendations and the Fife Enquiry 41. There are common themes in the recommendations in the two reports. Both highlighted the need for improved practice in recruitment and selection of residential child care staff, the importance of “whistleblowing” and complaints procedures, the safeguarding role of external people visiting units, and the use of restraint. All these were issues at Kerelaw, as this Inquiry has shown. We saw in the files that Glasgow City Council was aware of those reports, and of others over the years in England, and considered the implications for its own services. There were references to previous Inquiry reports in the Staff Code of Conduct. In 2001 attention turned to recruitment, and procedures at Kerelaw were tightened and brought into line with the Council's policies. But we did not see or hear much evidence that at Kerelaw itself these Inquiries had much impact. We have already seen at paragraph 12.19 that, while the Council reviewed its complaints procedures, Kerelaw seemed to be able to opt out. We have already noted the insufficiency of external management, the concerns of CROs, the drift in refresher training for TCI and the lack of a central overview of the use of restraint.

Conclusion

13.47 Glasgow City Council's stewardship of Kerelaw was unsatisfactory. local government reorganisation in 1996 was a factor, in that Glasgow City Council faced extremely serious budgetary problems which preoccupied senior management and diverted attention from other priorities. Partly as a result of that, Kerelaw did not receive from external management the attention it should have had. While the findings of other Inquiries were considered by the Council, the lessons appeared to have little impact at Kerelaw. External management was insufficiently proactive in ensuring that they were followed up. External management responsibility was also delegated inappropriately and inadequately resourced and its failures were an important contributor to what went wrong. These failures were compounded by poor relationships at senior level in Social Work HQ.

14. THE CLOSURE OF KERELAW

14.1 The Open School at Kerelaw closed at the end of December 2004 and the Secure Unit in March 2006. A number of former employees suggested to the Inquiry that Glasgow City Council had been waiting for an opportunity to close the school and the speed with which they did so was evidence of that. By extension, some argued, abuse allegations were exaggerated and a witch-hunt was pursued against staff to justify the decision. Linked with this, it was suggested by some that the Council called on the Care Commission and HMIE to bring forward the next scheduled inspection to August 2004 as cover for a decision which had already been taken.

14.2 A variation on this claim is that, if the situation was as bad as it was alleged to be in August 2004, the report of the Care Commission/HMIE November 2003 inspection would have been much worse than it was; or alternatively, the situation deteriorated so badly after June 2004 because the Council removed the Principal and a large number of staff following the Millerston investigation and the report to the Directors, and because the Deputy (Open School) was also absent on sick leave.

14.3 The turmoil after June 2004 will certainly have had an impact, but there are flaws in such reasoning. As previously noted, the report of the integrated Care Commission/HMIE inspection of the Open School in November 2003, which was published in April 2004, was far from satisfactory, although it did note positive features as well as weaknesses. Inspectors identified 4 key strengths, including improvements to aspects of residential accommodation, but, as we discussed at paragraph 10.39, there were also a number of concerns, which included follow-up to the previous inspection, and planning for improvement.

14.4 The Inquiry can see why some might argue that, if the position at Kerelaw was as bad as that described in the report of the August 2004 Care Commission/HMIE inspection, the April 2004 report of the November 2003 inspection would have been much worse. However, while no specific child care protection issues were highlighted, it was noted that staffing levels within the units were inadequate at times, an issue which the Principal had been raising with HQ, and there were concerns around climate and relationships and other areas. There was moreover, “soft information” which was shared among inspectors prior to the August 2004 inspection which indicated that they had a number of serious concerns which had developed over a period of time.

14.5 This “soft information” referred to concern about the effectiveness of senior management, and raised questions around external management, a macho culture, a bullying management culture, staff cliques and relationships, information weaknesses, night staff attitudes, and TCI. All of these are issues identified as problematic by the Inquiry from the evidence we received. We were told by the Care Commission that the information had been collated from staff who had been involved in previous inspections, but as we have noted (see paragraph 11.11), although these were therefore presumably present in the minds of at least some inspectors at the time of the Care Commission/HMIE inspection in November 2003, they were not reflected in the April 2004 report. As we have noted, concerns clearly identified by others, including those involved in inspection, failed to translate into concerted action to put things right until August 2004.

14.6 The Inquiry is aware that, although on occasions some placing authorities were sufficiently worried about the safety and well-being of particular children to move them from

Kerelaw, they continued to use the school. While in some cases they were bound by Panel decisions in relation to secure accommodation which specifically named Kerelaw, it appears that many individuals and authorities were unhappy about Kerelaw over the years. They were able to overcome their reservations, and the fact that they did so may be an indication of how convenient, or indeed essential, Kerelaw was considered to be at the time as a resource for dealing with their most challenging young people. Their continued use of Kerelaw cannot be construed as evidence that there were no concerns until after the Millerston investigation in 2004, the change in the management team in June, and the suspension of staff.

14.7 A further flaw in the argument that abuse was exaggerated as part of a hidden agenda to close the school is that the report of the August 2004 inspection clearly implies an expectation that Kerelaw was to continue as a going concern. The report outlined planned follow-through inspection activity and indicated that an action plan had been sought from the Council on how it proposed to address the main findings. The intention was that the Care Commission and HMIE would monitor progress and that an interim report would be published within six months. The report noted the intention of the Care Commission and HMIE to conduct a full follow-through inspection within two years.

14.8 It is possible that Glasgow City Council hoped to use the findings of the Care Commission/HMIE inspection to provide cover for a decision that had already been taken to close the school, but we found no evidence to support that. We were told by a number of witnesses that the Directors of Social Work and Education visited the school in June 2004 and told managers that it would close, although when we checked this, we were informed that it related to a decision to close the school to new admissions while investigations continued, not to shut it down. We also heard in evidence that, when the external manager was put in charge of the school in June as acting Principal, his remit was to continue to operate Kerelaw as a going concern, and admissions to the Secure Unit resumed in August. We also saw papers suggesting that work was continuing to be taken forward on the plans to rebuild the Secure Unit.

14.9 It does not appear to the Inquiry that a decision had been taken to shut down Kerelaw as early as June 2004, although it seems that the view began to form at a senior level that closure might be the most appropriate outcome. The fact that Kerelaw was operating with lower numbers following the agreement to restrict admissions in May, and the closure to new admissions in June, had financial implications. A report to committee in August 2004 noted that numbers in the Open School had fallen to just over half its capacity of 50, although there had been only a small reduction in the Secure Unit. It stated that, prior to June 2004, Kerelaw generated approximately £5.9 million revenue through the sale of places against a budget of £5 million.

14.10 Although Glasgow City Council itself was the source of much of that revenue, it was forecast that, if the ban on new admissions at the Open School continued, numbers would reduce to zero by early 2005. An income loss of over £2 million to the Social Work Budget was said to be the estimated consequence, although another important calculation would have been the additional cost of accommodating 50 young people in alternative, more expensive, residential accommodation. The report noted that there were at the time 116 Glasgow children resident in voluntary sector schools and secure units at a cost of nearly £11 million.

14.11 The report also noted that the intention was to rebuild the Kerelaw Secure Unit on the present site with financial assistance from central government, and that there was potential

for the Open School to provide complementary services alongside this. It was pointed out that if Kerelaw did not exist, other more expensive options would be needed. It was suggested that the Open School required to be modernised, that the opportunity to reduce numbers should be taken, and the feasibility of developing more specialised, high quality services should be explored. The report envisaged a progress report, in the light of the Care Commission/HMIE inspection and the investigations, to include options and proposals for service development at Kerelaw School. There was no recommendation at that stage that Kerelaw be closed down.

14.12 The Inquiry was not able to find a written audit trail leading up to the proposal which went to Committee on 15 October 2004. A Sunday newspaper report on 26 September claimed that Kerelaw was facing the axe and “an insider” was quoted as saying that the Care Commission report was very, very serious. An article in a tabloid newspaper at the end of the month asked if Kerelaw was doomed and referred to the Care Commission’s serious concerns. Although we found no evidence, it might be inferred that views within the Council were moving towards closure and that these were leaking to the press,

14.13 We heard in evidence about growing concern among a range of elected members at what they were hearing about the police inquiry and the impact of the internal investigations on the running of Kerelaw. We were told that “a feeling just grew” that closure was probably the best option. It appears that this feeling solidified into something much firmer from sometime in the Summer. On 12 October, the same day as the Care Commission served an Improvement Notice on the Council, the Directors of Social Work and Education wrote to Kerelaw staff saying that the Care Commission/HMIE Inspection report would be published on 15 October, and that they would be recommending closure of the Open School consistent with Council policy to reduce use of residential care. They said they would also be recommending continuation of the Secure Unit under an alternative supplier. Two days later, a press report, accompanied by a photograph of the Director of Education, said that Social Work chiefs wanted Kerelaw closed.

14.14 We alluded in Chapter 6 to the policy debates which have surrounded residential child care over a number of years. In common with other authorities, Glasgow City Council embraced the proposition that alternatives to residential child care should be developed. We also formed the view from the evidence we heard that a number of senior Social Work managers had been for some time at best sceptical about the role of residential establishments in meeting the needs of the Kerelaw client group, although not, it would appear, to the point of stopping sending young people there.

14.15 In February 2002, the Director of Social Work (by 2004, the Director of Education) had reported to committee on a proposed realignment of residential child care within Glasgow, in which he described the number of placements in children’s units as being in excess of the Council’s capacity. The paper noted that the top priority for the following 5 years was to continue to shift the balance from residential to foster care, and to reduce the number of looked after children in residential establishments. Closure of Kerelaw was therefore consistent with Council policy, but it seems unlikely that, without the catalyst of the Millerston investigation, the subsequent explosion of allegations, and the August 2004 Care Commission/HMIE inspection, it would have happened when it did.

14.16 The report to committee on 15 October 2004 recommended a decision in principle to close the Open School by the end of the 2004-05 financial year and to continue to take no

further admissions. There was a statutory requirement to consult and the Director Social Work was authorised to do so. The Scottish Executive was to be advised that the Council was seeking an alternative provider of secure care and discussions subsequently took place with the Scottish Executive and with other providers. One such provider became involved in negotiations over a period of many weeks, but in the event no agreement was reached and the Council continued to run the Secure Unit until March 2006. The Open School closed rather more quickly than anticipated, at the end of December 2004.

Arrangements for residents

14.17 Once Glasgow City Council had decided to close Kerelaw, plans had to be made for the young people still living there. The Inquiry learned that the 4 young people on sentences in the Secure Unit were able either to complete their sentences at Kerelaw or move on to prison at 18 as planned.

14.18 The Inquiry heard that, when staff and young people were told in October 2004 that Kerelaw was closing, there was considerable grief. At this point many employees were suspended and 2 units in the open school were closed. We heard that staff and young people were distraught, which was in contrast to their previous feelings. We heard that young people still living at Kerelaw wrote to the Director of Social Work as they felt they had not been involved in the decision to close, or in the investigations. They also complained that Care Commission officers had not spoken to them during the August 2004 inspection and they wanted to say they had a good experience at Kerelaw. However, the Care Commission told the Inquiry that the inspection team spent around a week at Kerelaw in August 2004 and engaged with a large number of young people. We heard that, following the closure decision, the Director went to Kerelaw and spoke to the young people, but we gained the impression that the impact of announcing the closure of Kerelaw on those young people living there had not been anticipated or planned for. Yet, for some of those young people Kerelaw was home.

14.19 The Inquiry was told that the Council involved advocacy workers in care planning as they moved young people on to other placements. We heard that rigorous efforts were made to ensure that young people were appropriately placed. The Inquiry read minutes of the Secure Screening Group in Glasgow, including some “Kerelaw Care Plan Discussions” from early 2006. These involved the young people remaining in the Kerelaw Secure Unit as it approached closure. These minutes suggest that a thorough and individual approach was taken to planning for this group of young people.

Conclusion

14.20 The Inquiry considers that closure of Kerelaw was consistent with Council policy to reduce its reliance on residential accommodation for young people, but found no evidence that a decision to shut down the establishment had been taken before the Care Commission/HMIE Inspection in August 2004. The Inquiry does not consider that the change in senior management in June 2004 was the sole or main reason for the adverse report that preceded the closure of the school.

15. THE GLASGOW CITY COUNCIL INVESTIGATION AND DISCIPLINE OF KERELAW STAFF

15.1 As described in Chapter 7, the setting up of the joint investigation followed the Millerston investigation and the continued emergence of allegations. The police were informed following the June meeting referred to at paragraphs 7.19 and 7.20. Separate historical allegations had also been raised and brought to police attention. The investigation team was “joint” in recognition that Kerelaw provided both education and care, and that education and social work needed to work together, although its composition and its investigatory work became heavily weighted towards social work experience.

15.2 An officer was chosen to lead the investigation who was not currently part of the HQ Children and Families team, but was considered to have the policy and analytical background to carry out the work. This officer also had a trade union background, and had in the early 1990s been lead trade union officer in a number of joint management/trade union investigations under Strathclyde Regional Council’s conduct and competence procedures.

15.3 After the lead official was identified in the Summer of 2004, the remit - to investigate current and historical allegations of abuse - was agreed at Director level. The team was asked to consider the issues which had emerged from the Millerston investigation, including the inappropriate use of restraint. There were also health and safety issues. The initial timescale was estimated at 3 to 6 months. In the event they were only wound up only in 2008. The lead officer liaised with the officer who led the Millerston investigation to draw together the concerns that had emerged. Previous fact-findings at Kerelaw were also scrutinised. As the investigations got under way, more than 20 staff had been transferred or suspended, including managers.

Investigation team

15.4 Over the 3 years of the investigation 12 people were involved in the team for varying periods of time, in addition to the lead officer. The initial team of 6 was put in place between August and November 2004 and 6 more joined in the Spring of 2005. One of the original 6 was from the Education Department. The rest of the team comprised a mix of staff with experience in residential child care, child protection, fieldwork, criminal justice and human resources. They were all at the level of first line manager or above. The team were off-line from their substantive posts for the period of their involvement, which varied from a few months to 3 years, and were managed by the lead officer, who in turn reported direct to the Director of Social Work.

15.5 Some people have criticised the investigation team as not having the necessary experience of residential child care to allow them fully to understand Kerelaw’s role. However, the team did include officers with direct experience of residential care and external management. As the investigation progressed, the benefit of having more people from a fieldwork background was recognised, and this was achieved as new team members were recruited. In particular, officers with child protection experience were sought out and invited to join the team.

15.6 A number of the team had previous experience of carrying out fact-findings and had previously been trained in interviewing. Some had been trained in investigative interviewing in child protection. The whole team was trained in Glasgow City Council’s disciplinary

process. The team asked for, and was given, training in TCI. In interviews with the Inquiry, members expressed varying levels of confidence in how well prepared they were for their role in the investigation. All acknowledged the work was different from anything else they had ever been involved in before. This was largely due to the number and seriousness of the allegations and the sheer volume of information to be gathered and considered. Another difference was that, unlike most fact-findings, this was about a group of people, not one individual, and although many complaints were relatively recent, it included historical allegations.

Support for the investigation team

15.7 The nature of the work posed challenges around supporting investigators in their task. One came from a background in HR, but functioned as any other team member. While this officer was able to assist the team on matters of process, another person from HR had to be allocated to provide HR advice and support. The team was able to consult other HR staff for advice about communications with employees, questions which could be asked at fact-findings, and what could and could not be put in reports. The team was able to call on the Council's legal services for advice on matters of law.

15.8 As investigations were confidential, and as they were outside their normal reporting arrangements, team members were unable to talk even informally to non-team colleagues, and this meant a degree of isolation as they carried out their work. Some were shocked at what they heard from young people and from some staff members, and told us this had an emotional impact on them personally. Despite that, no special support was offered to team members when they moved on after the investigation. We were told that confidential employee counselling was available to them in the same way as it was to all Council staff. Some of the team were able to seek out other support, but it was clear to the Inquiry that others still feel they should have been formally debriefed at the end. A number of them continue to be affected and might have benefited from the opportunity to talk about their experience. Some ex-members of the investigation team, like a number of former Kerelaw employees, told us that being interviewed by the Inquiry was the first opportunity to do so and the only debrief they had.

Working as a team

15.9 The Inquiry learned that the expansion of the team through the addition of 6 new members in 2005 exposed some divisions, both physically and in perspective. The new team members were based in another room in a different part of the building. The original team were already fully engaged in the work of the investigation and new members appear to have had some difficulty in becoming fully absorbed. Some who gave evidence to the Inquiry suggested that they functioned as two separate teams during the remainder of the investigation. Some of the newer members told the Inquiry that they had approached their remit with open minds but were surprised to find existing team members already convinced of the culpability of Kerelaw staff. This may be explained by what the initial investigations had yielded up to that stage, and there does seem to have been some open discussion within the wider team about differences of perspective: for example on how far certain practice was deliberately abusive or the result of poor management and insufficient supervision and support. We formed the impression that the differences were never fully resolved.

15.10 The one education representative, who was part of the team for about a year, dealt with allegations against 2 teachers and then went back to his substantive post. Both of the cases proceeded to the discipline stage. We were told that allegations which came to light about teachers at a later date were passed on to the Education Department. There were no further disciplinary outcomes for teachers, but we were told that some teaching staff were called to the Education Department for discussions and some were referred to DWCL and GTCS. In that regard, the investigation did not seem to the Inquiry to have been as all-embracing as it should have been.

Working with the police

15.11 There was no joint investigation with the police, contrary to the expectations of some people in Glasgow City Council. The internal investigations and the police inquiry took place in parallel. There were regular formal meetings for sharing of information, and a great deal of informal contact between the police and the internal investigators. To some of the latter it felt like a joint investigation. To others it clearly did not, and there was frustration that they were not working jointly in a manner to which some had been accustomed in child protection cases. The Inquiry was told that the deciding factor in there being two investigations, rather than one joint one, was due to the historical nature of the initial allegations which had come to police attention separately, and that for the police it was not a child protection investigation into an immediate risk.

15.12 There was confusion among some team members about the relationship with the police and the mechanism for working together. Social workers are accustomed to passing information to the police where they believe a crime has been committed, and letting them investigate and make decisions about putting the case to the Procurator Fiscal. However, the range of allegations leading to referrals by the internal investigators to the police became very wide and led internal investigators to believe that many were not pursued, as the police focused mainly on the “high tariff” – ie largely sexual – allegations. In fact, the police did investigate and report a broad range of criminal allegations, both of a sexual and non-sexual nature, to the Procurator Fiscal. All reported allegations were treated seriously and investigated by the Procurator Fiscal, before being reported to Crown Counsel, who considered the full facts and circumstances of each individual case before making a decision.

15.13 As more and more people were named in interviews with witnesses and the net began to widen, it is understandable that the team might find it difficult to decide what should and should not be passed on to the police. An open debate as to whether investigators were uncovering crimes or poor practice might have been useful. On the other hand, it would have been risky for the Council to decide that any particular case did not warrant informing the police. Statements to the police were not shared with Council investigators and for the latter to make a judgement as to whether an individual against whom allegations had been made was probably guilty of no more than poor practice might not have been borne out by information available to, or obtainable by, the police.

15.14 The police were clear that their Inquiry took priority, and a consequence of that was that at one point they required all the records and moved them to Ayr police station. The internal investigation team then had to consult them there. The flow of information became a problem and accessing witnesses, itself a time-consuming task, became more complicated. The fact that there were two different investigations was confusing for many former residents. Some witnesses did not want to speak to Council investigators after they had

spoken to the police, as they saw no reason to tell their story twice, in their view to satisfy a bureaucratic process. The Inquiry was also told that, after being notified by the Fiscal of decisions not to proceed with the cases in relation to which they had given police statements, some former residents became even more reluctant to speak to investigators from the Council, as they concluded that they had not been believed. The Inquiry considers that the separate nature of the two respective investigations lengthened the process and made it harder for the Council investigators to obtain statements from potential witnesses to abuse.

Time taken for investigations and disciplinary action

15.15 Glasgow City Council has been criticised for being both too eager to pursue disciplinary action against individuals, and at the same time for being too slow to complete the process. Initially, there would certainly have been pressure on the team to get on with their investigations and to decide on recommendations for disciplinary action. The fact that by the time the investigation started in 2004, over 20 people were already suspended or transferred, would alone have led to considerable pressure to move forward quickly. But moving the investigations forward as quickly as had been hoped was complicated by the volume of allegations which emerged as witnesses were tracked down and interviewed, and also by the police investigation.

15.16 Although there were 3 different District Procurators Fiscal in overall charge between 2004 and 2007, the Crown Office has maintained that the dedicated team of staff in the Procurator Fiscal's office who were preparing these cases were unaffected by these changes. The prosecution position is that the Crown worked as quickly as possible both to clarify matters for individuals and in relation to allowing the Council to proceed with its own processes. In the event, most of the cases did not result in prosecution but, as late as the Summer of 2007, the Glasgow Report was referring to 5 cases still being outstanding. The Inquiry established with the Fiscal in 2008 that in fact no cases remained outstanding and understands that letters were sent to the individuals concerned or their legal representatives to inform them of that.

15.17 Despite that, we heard from one individual who claimed in 2008 that he still had not heard whether or not he was to face Court proceedings. The Crown Office position is that, while the Crown does not routinely intimate decisions to take no proceedings in such cases, the Fiscal always endeavours to respond quickly to enquiries. The wording of the letter which said that no proceedings would be taken on the basis of information available, left a number of people unsure as to what might happen in the future. The Crown Office told the Inquiry that this careful wording is necessary in light of established case law that an unequivocal statement by the prosecutor that there are to be no proceedings will bar any proceedings at a later date, even if new and compelling evidence comes to light. The Inquiry was told that the terms of the letters follow long-established practice, designed to avoid excluding the possibility of subsequent evidence emerging which might provide a sufficiency of evidence, where none had existed previously. We understand that, but a consequence was that there remained much anxiety in the minds in some of those against whom allegations had been made and investigated.

15.18 It appears that the investigation team felt under some pressure to enable the Council to move to disciplinary action, where this was indicated, without undue delay. However, we found no evidence of political pressure on investigators, or pressure by senior management in the Council, to achieve particular disciplinary outcomes, although we are sure that there will

have been concern at the highest levels to ensure that there would be no accusations of cover-up. We were told that the political instruction to the Director of Social Work was “to get in there and sort things out”. Senior management evidence to the Inquiry was that the priority was to establish facts.

15.19 A countervailing pressure on investigators was the need to be as thorough as possible. As the investigation continued, more and more names of potential witnesses, both staff and former residents, emerged. Tracking down former residents was to prove a lengthy task. A particular problem for investigators was how to achieve a balance between tracking down more and more witnesses to build up evidence, and “drawing a line” under individual cases one way or another in order to minimise delays. The team leader reported progress in her regular meetings with the Director of Social Work and it was largely up to her, consulting as necessary with HR, to decide whether there was enough evidence to recommend proceeding to disciplinary action. Where such action followed, the relevant team member would be the lead witness in the Council’s case against the individual concerned.

15.20 Although disciplinary action was taken against a number of individuals before the police investigations were concluded, the time taken in both the disciplinary and police processes led to many people being suspended from their posts for very long periods of time, in some cases for up to 3 years. We were told by many of the ex-Kerelaw staff we interviewed that they were suspended and then went for weeks and months without any contact from Glasgow City Council. A number told us they had been warned not to speak to anyone else from Kerelaw in the meantime, which meant that they felt very isolated, sometimes for a long time.

15.21 Despite the regular progress meetings involving the team leader and the Director of Social Work, we were not aware that an opportunity was taken for the investigation team and the latter to take a step back from time to time to take stock of what was happening. As the size of the investigation grew, it might have helped for the Council to reflect on developments and give consideration to speeding up the process. That might have been done by seeking support from other Departments within the Council or from Social Work Departments in other local authorities, or by buying in additional HR advice. It might have had the added advantage of increasing the expertise in disciplinary procedures, on which we shall say more below.

Conduct of the investigations

15.22 A number of witnesses to the Inquiry were angry that members of the team had uncovered and were reinvestigating allegations that had previously been investigated and dealt with. Glasgow City Council’s disciplinary procedures are explicit that expired warnings from previous disciplinary hearings will be expunged from the employee’s record. Union representatives successfully argued in some cases that, where investigations in the past had led to disciplinary hearings, such cases should not be reopened. By extension, previous investigations that did not result in disciplinary action should not have been revisited either.

15.23 However, others argued that, as investigations were for the first time “joining the dots”, it was appropriate to take account of any history of allegations, particularly where it appeared to investigators that previous fact-findings had led to unsatisfactory outcomes. This would rectify what they saw as failures of management and supervision in the past. This issue was not wholly resolved. The fact that there had been investigations of allegations of physical

abuse over a number of years, with a core of individuals apparently involved, did contribute to building a picture of a culture at Kerelaw which was unsatisfactory, but it became rather more problematic when used to build up a case for disciplinary action against specific individuals.

15.24 Many former employees of Kerelaw and their families have asserted that Glasgow City Council's investigation was a "witch hunt" in which staff were scapegoated and treated unfairly. None of the ex-Kerelaw staff we spoke to who had been involved in the investigation felt that they had been treated fairly by the fact-finding and disciplinary processes, apart from one who said he had no complaints. This overwhelmingly negative commentary may not be surprising in the case of those facing allegations. However, the numbers include not only those who were the subject of allegations but also those whose sole involvement was to be interviewed and called as witnesses in relation to allegations against others.

15.25 A common complaint from individuals who gave evidence to the Inquiry was that they were not told about the allegations against them until they attended the fact-finding interview. Even then, they argued, the information provided about allegations was often too vague to answer adequately. Sometimes they could not recognise the incident at all or identify the alleged victim or anyone else who was involved. The response by those involved in the investigations was that a fact-finding is just that, so that establishing exactly what the allegation amounts to can be an important first step. Some of those investigated complained that if fact-finders had done their work better, various allegations could have been quickly discounted, because dates of employment and residency that made a situation impossible would have been checked.

15.26 We recognise that in some cases investigators found it hard to find adequate written records, but it does appear that in some cases basic, easily checked, facts were left unchecked. We saw examples where staff were accused of doing something in a particular year when records showed that they did not work at Kerelaw at the time. This could simply be because the witness had got the year wrong, an understandable problem when dealing with events that may have occurred several years earlier. Alternatively, the witness might have got the staff member's name wrong – a mistake with potentially very serious consequences, unless thoroughly checked out. Some ex-Kerelaw staff complained that during the fact-finding the interviewers were even wrong about the number and nature of allegations and had to be corrected. Details of that kind were not always properly checked and sometimes only came to light at disciplinary hearings.

15.27 The Inquiry does not consider that the incidence of this was such as to undermine the overall conclusions reached as to whether abuse occurred at Kerelaw as we received adequate evidence of that from the Inquiry's own witnesses. However, failure to check factual details runs the double risk of individuals either being wrongly pursued or of not being pursued who should be. It also provides ammunition to those with an interest in discrediting the entire process, of whom we encountered a large number.

15.28 Some individuals and their representatives complained that they were not given access to information that they needed to offer an explanation or to construct a defence for their disciplinary hearing. They complained in particular that they were not allowed to see the statements of those who had made or corroborated allegations against them. The Inquiry saw and heard evidence of the Council's concern that the disclosure of information during the

disciplinary process would create risk of harm to third parties, notably to Kerelaw residents and ex-residents and to Kerelaw staff. There was also a concern that disclosure might in other ways undermine their ability to get to the bottom of matters during their investigation. Not making statements available was no doubt justified in the circumstances as we were told of verbal abuse, threats and intimidation in the local community of staff thought to have been whistleblowers, and of their families.

15.29 Some of those investigated who asked to see the note of their interview felt this did not properly represent the discussion that had taken place, and found the investigation team extremely reluctant to make the changes they requested. Others described making many changes to the statements they were sent but finding that their amendments were not taken on board. In response to this, investigators told the Inquiry that notes of interviews were not verbatim records, but were intended as a fair summary of what they were told. They took the view, which the Inquiry accepts, that it was not appropriate simply to accept substantial changes to what had been said after witnesses had had a chance to reflect on how their statements had come out and in some cases substantially change their story. Investigators said that, where changes were offered, they were prepared to note them in red to highlight where the individual disagreed with the record. The disagreement was then able to be taken up at the disciplinary hearing, if that followed.

15.30 We heard frequent claims by former employees at Kerelaw of aggressive interviewing styles during fact-finding. This could readily be inferred from some of the notes of interviews which the Inquiry read. The Inquiry also heard complaints from a range of ex-staff about the leading nature of questions asked by interviewers, of both former residents and employees. This was also apparent in some of the notes of interviews we read. It was put to us in evidence that anyone questioning or doubting the evidence or fairness in the process was regarded by investigators as insufficiently child-centred and on the side of abusers. One former staff member who was called to give evidence to investigators told us that:

He was called up 3 times to give information.....if he didn't tell them what they wanted to hear he felt as if they thought he was telling lies. They discounted what he said if it wasn't what they wanted to hear.

15.31 It was also put to the Inquiry by some former staff members and their representatives that some people were treated as credible witnesses when giving evidence against other staff members, but as lacking credibility when talking about themselves. If this was indeed the case, and it was not the perception of those involved in carrying out the investigations, it could fuel a perception of bias and prove counterproductive in the long run. However, it must be borne in mind that child abuse is notoriously difficult to investigate as perpetrators almost invariably deny their guilt. If investigators appeared over-eager to achieve a result, this was most likely due to their concern for children, and in an investigation the benefit of the doubt has to fall on the side of their protection.

15.32 The Inquiry recognises that being interviewed about allegations of child abuse must be a traumatic experience and that the more robust the interviewing style the more difficult the experience will be. Within a few months of investigations starting, the team became increasingly aware of previous allegations, sometimes over a long period, against a number of individuals whose names were being drawn to their attention. They uncovered evidence of less than satisfactory previous investigations, of associated concerns about staff collusion, of

failures in the complaints system, and of the fact that concerns on all such matters had been raised by others in the past.

15.33 As this emerged and as allegations multiplied, for some investigators their determination to establish the facts and bring perpetrators to book may have hardened, and this may have been reflected in their approach. Although a determination to ensure that on this occasion there would be no covering up and no obstruction is laudable, employees who are subject to fact-finding should nevertheless be treated with respect. That does not mean that they must be treated with kid gloves: rather, the questioning must be firm but fair, penetrating and insightful, well conducted and properly documented. The Inquiry saw some evidence of good, well-constructed questioning of that kind, which was effective in eliciting the information which was needed.

15.34 One witness to the Inquiry who had been involved in fact-findings at Kerelaw in the late 1990s summed up what he recalled as the challenge involved in getting at the truth:

...there was frequently a collusive atmosphere where staff seemed uncomfortable when backing up a story and it was hard to get to the truth....a number of staff were disproportionately involved in a number of complaints, and on a number of occasions experienced staff were saying they were around at the time of a particular incident when young people did not. That made [him] conclude that collusion was embedded in the management structure. [He] speculated that it seemed staff had had a dummy run through fact-findings in advance to get their stories straight. Cliques were common and both he and felt staff had been coached on occasions.

15.35 It is also important to appreciate the challenge involved in putting together evidence in respect of individual cases which would stand up to the burden of proof, even where the same names came up frequently in witness statements. This had been well evidenced by previous experience at Kerelaw. Like fact-findings in the past, the investigation was hampered by the different allegiances of staff. The Inquiry interviewed a former employee who had cooperated with the investigation and had given accounts of an unacceptable situation which had been poorly handled by a range of Kerelaw managers and staff. She had been dissatisfied at the outcome of the investigation into that incident, believing that those responsible had covered up for one another and had not been properly held to account. She believed they had a case to answer.

15.36 However, when subsequently asked to provide information in a separate investigation of one of her peers, she refused and withdrew cooperation from the fact-finders. While the Inquiry is not in a position to take a view on the merits of the respective allegations, the willingness of this staff member to cooperate appeared to be coloured by who was under investigation. This illustrates the difficulty facing investigators in obtaining open, reflective information from some staff members who had allegiances to particular individuals or groups. Nor was fact-finding helped by the outright refusal of some employees – sometimes having been so advised by their union representative - to offer any comment at all on certain allegations. While “no comment” is any accused person’s right, it is unhelpful and it is not surprising if negative inferences are drawn from such a response.

Attention to detail

15.37 The Inquiry was surprised at what appeared to be a lack of attention to detail in some fact-finding reports. Although there were some well-constructed, appropriately analysed, rationally argued and carefully concluded reports, rather more were poorly written, hard to follow and loosely concluded. Indeed the Inquiry heard that the poor quality of the fact-finding reports was a significant factor in Glasgow City Council withdrawing from the Employment Appeals Tribunals in relation to two teachers. Some fact-finding reports did not appear to have been proof-read and this gave the impression that there had been a lack of quality assurance in their production. While the misspelling of the same individual's name at different points – and sometimes in different forms - in a written note of an interview may not undercut the substance of the note, it raises the question as to what else may not be quite right. In the most extreme case it may cast doubt on the identity of the person concerned and may thereby make it harder to substantiate allegations. If the motivation for pursuing investigations robustly and single-mindedly is to ensure that young people are safe, apparent carelessness of this kind runs the risk of having the opposite effect.

15.38 The way in which Violent Incident (VI1) forms had been completed or otherwise dealt with was an important element in cases against senior managers. Despite this, these were not as well ordered or checked through as they might have been. Those presenting the management case at disciplinary hearings sometimes had to seek out the forms being adduced in evidence after the hearing had commenced, which is unsatisfactory. There were problems with certain other aspects of paperwork and record keeping, which should have been more rigorously audited and presented. The fact that “the accused” had often not had the opportunity to see and comment on the documentary evidence was an issue addressed in the Principal's Employment Appeals Tribunal.

15.39 The quality of evidence gathered by investigators from witness statements and records they examined was tested first in disciplinary hearings, then in appeal hearings by Councillors, and in some cases in subsequent Employment Appeals Tribunals. The evidence stood up well to the tests in some cases, and in others it did not. The varied nature of disciplinary outcomes, and the outcome of Tribunals, reflect that.

15.40 It is important to bear in mind that evidence which may allow a general conclusion to be drawn in relation to unacceptable practices, a prevailing culture, management failures, or other shortcomings, may have to be more robust to establish that a particular individual is guilty of commission or omission of a specific act at a specific time or place. If disciplinary action is to ensure that individuals who are guilty of misconduct are held to account, it is vital that close attention is paid to the quality of evidence, and that it is scrutinised carefully by the employer's legal advisers. The Inquiry considers that the legal scrutiny of a number of cases as they went forward to disciplinary action could have been more thorough. It is also crucially important that the process followed is compliant with the law and the employer's own procedures. We return to this below.

Outcome of the disciplinary process for ex-Kerelaw staff

15.41 The Council's investigation resulted in 29 disciplinary hearings which gave rise to a number of internal appeals and Employment Appeals Tribunals which have extended over a period of more than 4 years, and are not yet complete. There appears to have been no further action following the fact-findings for the remaining 9 people. Of the staff who were subject to

a disciplinary hearing, 14 were dismissed over a period from December 2004 to October 2006. Twelve of those who were dismissed appealed to the Council's Appeals Sub-Committee and one appeal was upheld with a reduced penalty of final written warning. Subsequently, 9 of those who were dismissed and appealed took their cases to an Employment Appeals Tribunal.

15.42 The Principal and the Deputy (Open School) had their claims of unfair dismissal upheld at Employment Appeals Tribunals and will receive compensation. The Council has conceded a further 2 cases and those staff will also receive compensation. Two ex-members of staff have dropped their claims and another has been struck out by the Tribunal because of the appellant's failure actively to pursue the case. The other 2 cases remain active. The disposals for the 15 Kerelaw staff who were not dismissed following a disciplinary hearing varied. For 3 there was no further action and they returned to work; 3 were subject to a management discussion and also returned to work; 7 received final written warnings and the Inquiry has been unable to establish the outcome for 2.

Glasgow City Council's Discipline and Grievance Policy and Procedures

15.43 At local government reorganisation in 1996, the discipline and grievance policy and procedures used by Glasgow City Council were those of the former Strathclyde Regional Council, as were many of the Council's policies and procedures. However, by May 1997 the Council had reviewed the existing policy and rolled out its own Code of Discipline, Disciplinary and Appeals Procedure together with Grievance and Dispute Procedures.

15.44 The Council's Code complies with statutory requirements and conforms to good practice (see Annex D). It makes clear that discipline within the Council need not be punitive and that it provides an opportunity to improve. It also makes explicit that the procedure should work as quickly as possible, consistent with thorough investigation of the facts at each stage. Unless in exceptional circumstances, disciplinary investigations and hearings will be undertaken within 2 working days of discovery of the misconduct, although it is noted that on occasions the timescales will require to be operated flexibly by the parties concerned.

15.45 The Code provides examples of gross misconduct that may lead to summary dismissal. Included are wilful injury to others, neglect of duty resulting in serious consequences, criminal convictions having a material bearing on employment, abusive behaviour towards colleagues and/or the public or customers of the Council, and exceptionally serious offences of unsatisfactory conduct.

15.46 Responsibility for ensuring the maintenance of disciplinary standards rests with Heads of Department, for example the Directors of Social Work and Education, who may in turn delegate that authority to another officer under their control. The Departmental Personnel Officer advises management on disciplinary matters, is present at the disciplinary hearing in matters of gross misconduct or serious misconduct, relays decisions, and assists management in preparation for appeals. The Council's legal officer assists in the preparation and presentation of Employment Appeals Tribunals.

15.47 Where a precautionary suspension of an employee is justified and is likely to extend over a period of time, the Code makes clear that the suspended employee will be kept informed of the reasons for the continued suspension at least on a 2-weekly basis. Where the fact-finding investigation indicates that a disciplinary hearing is needed, the employee should

be informed and given reasonable time to prepare his or her case and be given relevant copies of reports and documentation.

15.48 The Council's Disciplinary Procedure sets out clearly the stages of the disciplinary hearing and relevant responsibilities, how a decision is arrived at and the disposals that may result, their duration and the opportunities for appeal. There are no additional details or advisory notes in relation to timing of the process, other than that any appeal must be lodged within 2 weeks of receiving written confirmation of the decision and the time limits for disposals that do not involve dismissal.

Handling of criminal offences

15.49 The Code considers the Council's actions in relation to evidence of criminal activity that has a bearing on employment. The circumstances should be ascertained from the employee and the matter should be investigated as fully as possible before calling in the police. Where the police are called in, the disciplinary investigation and any police investigation should be handled separately and, before any decision is taken about disciplinary action, reasonable grounds must be established for believing that the individual committed the offence.

15.50 The Code makes clear that disciplinary action should proceed on the balance of probability and should not be swayed by the need for proof beyond reasonable doubt as the criminal case would require. There is no need to await the outcome of any criminal case in the Courts before proceeding with a disciplinary. Where a custodial sentence is imposed, the decision about whether to dismiss or not should take into account the need to act reasonably in the light of the needs of the Council.

Application of the disciplinary process

15.51 While the Council's Code of Discipline prescribes that disciplinary proceedings should conclude in a matter of days, it also allows for an apparently unlimited extension of time "on occasion". While the complexity of the disciplinary cases comprising the joint Kerelaw investigation must have precluded very swift completion, the looseness of the wording of the Code created an opportunity for the process to become greatly extended. Good practice suggests 6 months should be adequate for completion of a disciplinary fact-finding and hearing and this was significantly exceeded for a considerable number of staff.

15.52 As we have noted at paragraph 15.20, many of the ex-Kerelaw staff we interviewed said that Glasgow City Council failed to keep them informed of progress during their suspension despite the requirement to update at least once every 2 weeks. Some said that, despite hearing little direct from their employer, they did hear rumours about themselves and others about discipline-related actions that were about to happen, apparently so far as they were concerned through leaks of information from the Council. Leaked information found its way into the press too and some interviewees were – and remain – upset that they were named in the newspapers as child abusers. The Inquiry is not able to confirm or otherwise the source of any leaks which may have taken place.

15.53 Some of those who had been suspended told us that they had been given the name of an administrative support worker they could contact for advice, but that this level of support, delivered in this way, was inadequate under the circumstances. Others commented that the

support staff appeared to have no training or preparation for the task they were expected to undertake. One interviewee told us he had received 2 calls in 6 months from a junior administrator who had no idea how to provide support. Another said he had never been offered a contact person and that that was in contravention of the Code of Discipline. In contrast to these reports, however, a few interviewees told us they had been very well supported by a particular member of the personnel team. Given the protracted nature of investigations and the time taken for many of those against whom allegations had been made to come to a resolution of their case, it is not surprising that many ex-Kerelaw employees felt more and more abandoned by their employer as time went on.

15.54 Many interviewees reported actions by the Council that appeared insensitive to the impact those actions would have on individuals. Examples were letters reporting allegations that were despatched to home addresses without any prior warning and letters sent out late in the week which would arrive on a Saturday when Union or legal support was hard to come by. The Inquiry heard complaints that individuals were suspended or subject to precautionary transfer, sometimes by phone, without being informed of the specific allegations against them. For some, the detail of allegations remained unclear, while others feel they were informed of the details far too late in the process.

15.55 The evidence of those who were the subject of, or witnesses to, fact-findings, or were the subject of disciplinary hearings would suggest that the Council did not fully meet the statutory requirements in applying their disciplinary procedures. This is borne out by the outcomes in relation to 4 of the Employment Appeals Tribunals which have concluded to date. Delays in moving forward with an Appeal were a factor in the outcome of at least one Employment Appeals Tribunal. It appears to the Inquiry that the joint investigation paid insufficient heed to the rights of Kerelaw staff to fair and reasonable treatment in line with the Code of Discipline and disciplinary procedures.

15.56 The question arises as to whether this was the result of sloppy practice, a conflict of interests, or, as some interviewees clearly believe, an “agenda”, or some other reason. It is possible to conclude that where, for example, interviewees were faced with allegations that could have and should have been dismissed as impossible on the basis of facts that were easily checked, the fact-finding was sloppy and inadequate. That might allow some observers to conclude, regardless of the facts, that the whole investigation was flawed. The Inquiry would not support such a conclusion. Whether flaws in fact-finding resulted in poor or inappropriate conclusions as regards individuals, and the attendant possibility that guilty people have been exonerated and innocent people inappropriately disciplined, we cannot say, as consideration of individual cases was outside our remit.

15.57 As to whether there was an “agenda”, the Inquiry has no evidence that inappropriate pressure was put on investigators by politicians or senior managers, although there was clear political direction to investigate and sort matters out. There will also have been a determination to ensure that what some saw as the failures of previous investigations would not be repeated. It may also be that the investigation team had difficulty in accommodating the compliance requirements of a fair disciplinary process within an approach that made child protection the top priority.

Compensation

15.58 It was asserted by a number of former managers and staff, and some ex-residents, that the avalanche of allegations in which investigators were increasingly engulfed from Spring 2004 onwards was motivated mainly by a desire for compensation. These assertions were made partly by reference to experience of compensation being paid in recent years to the victims of abuse in a variety of settings. They were given weight because at the point in June 2004 that the external manager of Kerelaw was making his report to Directors, a young man for whose removal Millerston staff petitioned the Principal in 2003, approached the Principal himself to complain that – allegedly unlike other young people – he had not been informed that he could claim compensation for being inappropriately restrained. The Principal brought this to the attention of the Director of Social Work.

15.59 Unfortunately, the person who it was claimed had told young people this, one of those who had complained about her unit manager’s management style, did not come forward with evidence to the Inquiry; so we were not able to test the claim directly. Nevertheless, it is possible that some young people were told by someone at Kerelaw - in an effort to encourage them to speak up - that they could be eligible for financial compensation if they had been inappropriately restrained. It is also possible that some were encouraged to seek compensation by their solicitors.

15.60 It is possible that the prospect of compensation led to allegations which were not genuine. Just as for many years there was a reluctance to accept that abuse did take place in residential care, there has been in more recent times a reluctance to disbelieve allegations that abuse took place. Neither position is logically tenable. Allegations may be true, or they may not be true. Sometimes they may be partly true. But, because the people making the allegations may be disturbed or difficult, or may be capable of lying, does not mean that allegations will therefore be untrue. Discounting allegations made to investigators on the basis of the lives and background of those making them mirrors the attitudes which undermined the complaints system at Kerelaw, as discussed in Chapter 12.

15.61 The Inquiry team raised the possibility that young people were motivated by compensation in interviews with each member of the joint investigation team. All of those involved acknowledged the possibility, and said they themselves discounted testimony about which they had doubts. They were, however, persuaded that allegations were not made to enable residents or former residents to claim compensation, for a number of reasons. These included how witnesses presented, the fact that a number made positive comments about Kerelaw as well as making complaints, and the fact that many former residents were at first reluctant to speak in case they got someone into trouble. Another important consideration for the investigation team members was that successive “generations” of ex-residents, who did not know one another and who would have had no opportunity to collude, were coming forward with similar, but not identical, stories of abuse and poor treatment. Moreover, young people’s statements were often substantiated not only by other young people but also by staff.

15.62 Information held by Glasgow City Council shows that by 31 March 2009 a total of 55 former residents, or a family member, had notified compensation claims to the Council in respect of their treatment at Kerelaw. Of those, 4 predate by some time the beginning of the Council’s investigations, including the Millerston investigation, and only 2 of the 4 individuals concerned were subsequently interviewed by the joint investigation team. Of the total of 55 claimants at end March 2009, only 17 were among over 90 interviewed by the

investigation team, which strongly suggests that the hope of compensation was not the reason so many people came forward.

15.63 In contrast, it appears that the outcome of the Court cases against the teacher and the unit manager may have had the most significant influence on compensation claims, with 44 (80%) of the total of 55 claims recorded as having been lodged after the trial. Of those 44, over three-quarters refer specifically to one or other, or both, of the two convicted staff.

15.64 We do not rule out that a desire for compensation may have been a factor in some allegations which have been made against staff at Kerelaw, but the proposition that this was the sole or main motivation is not borne out by the available figures, or by what the Inquiry heard in evidence. This is consistent with the view expressed by Colton, Vanstone and Walby (2002)²³ :

Claims that those who have the courage to come forward and testify to the real and far-reaching harm that was done to them as children in public care are motivated merely by the lure of financial compensation should be viewed with scepticism; they may simply represent the misguided strategy of 'blaming the victim'.

15.65 The Inquiry does not agree with those who have disparagingly claimed that the prospect of access to a “pot of gold” resulted in investigators being hoodwinked by young people intent on lying to secure a share of it.

Support to former residents

15.66 Glasgow City Council offered some support to former residents of Kerelaw who were involved in the investigations. However, this support was limited and late in the day. From January 2006, the Council engaged the services of Barnardo’s to provide support to the former residents giving evidence at the criminal trial. Barnardo’s was well placed to offer this service as they already knew many Kerelaw residents, having worked with them over the years. They also had a free telephone line in place which young people could use to get in touch. The advice of the Crown Office and Procurator Fiscal was sought by the Council in arranging the support, given the need to ensure that the criminal process was not compromised. The Fiscal confirmed that the Council should not be directly in touch with witnesses, and as a result contact with all Crown witnesses to offer support by Barnardo’s was progressed through the Crown Office, who held contact details. However, as the Council approached Barnardo’s only 2 weeks before the trial, most of their work with the former residents took place after the trial.

15.67 Barnardo’s received a number of requests for support, some quite separate from the Court proceedings. The Inquiry heard that some residents had been advised by their solicitors against using a support service funded by Glasgow City Council. This suggests the support service may not have been as well used as it could have been. We understand that Barnardo’s provided support to 20 young people.

²³ Colton, Vanstone and Walby *Victimisation, Care and Justice: Reflections on the Experiences of Victims/Survivors Involved in Large-scale Historical Investigations of Child Sexual Abuse in Residential Institution* in *The British Journal of Social Work* 32, 541 – 551(2006)

15.68 Because of the nature of the police investigation, many of the former residents approaching Barnardo's were 35 to 40 years old. Barnardo's, as a children's charity, was unable to offer a service to those over 25. Barnardo's raised this with the Council, who agreed with the NHS that former residents over the age of 25 would be offered a psychological assessment followed by clinical support. At least one of the former residents who gave evidence to the inquiry was accessing this NHS support.

15.69 The Council's investigation team was aware of the support needs of those it interviewed. When the Procurator Fiscal decided not to proceed with a number of cases, many of the residents or former residents who gave police statements felt very let down. Investigation team members visited them to offer to link them to support services. As noted at paragraph 3.20, the Procurator Fiscal offered to meet the individuals concerned to discuss the reasons for the decision not to proceed, although only one meeting was requested by a former resident, who ultimately changed his mind before the meeting went ahead. The Inquiry heard that community social work services which were approached did not always offer support in these cases. Members of the investigation team suggested to the Inquiry that the Council had failed to anticipate the need for a support structure for former residents giving evidence to the investigation. The ownership of the process lay with the investigation team, which was inappropriate.

Conclusion

15.70 The joint investigation team set up by the Council faced a formidable challenge in terms of the number of allegations to be investigated and the unprecedented nature of its task. In its investigations of what went wrong at Kerelaw, Glasgow City Council rightly pursued allegations with vigour, but more care should have been taken by investigators to quality control the recording of statements, and to abide by the Council's own disciplinary procedures. The Inquiry found no evidence of political or senior management pressure on investigators to achieve particular disciplinary outcomes, but many staff, including some who gave evidence against colleagues, themselves felt abused by the way in which they were treated. The Inquiry concluded that the Council did not fully meet its obligations of care to all its employees during the investigation and disciplinary process.

16. DISQUALIFICATION FROM WORKING WITH CHILDREN

The legislation and its effects

16.1 The Protection of Children (Scotland) Act 2003 (“the Act”) provides for Scottish Ministers to keep a list of individuals whom they consider unsuitable to work with children – the *Disqualified from Working with Children List (DWCL)*. This list, which came into effect on 10 January 2005, aims to protect children (under the age of 18) from harm or the risk of harm by making it a criminal offence for anyone listed on the DWCL to apply for, offer to, accept or do any work in a child care position, whether paid or unpaid. It is also an offence for an employer to offer such work to, or to procure it from, an individual who is disqualified from working with children. Guidance on the operation of the Act was issued in December 2004, in March 2005 and again in January 2008.

16.2 When the information submitted with a referral indicates that an individual’s inclusion in the DWCL may be appropriate, that person is provisionally listed. This allows the individual to continue working in a child care position while further consideration is given to the case. Where known, a current employer will be informed of the provisional listing. The final decision to list is made on the balance of probabilities where Scottish Ministers are satisfied that the referring organisation reasonably considered the individual to have harmed or put a child at risk of harm and that that individual is unsuitable to work with children. Harm of any kind is relevant, including psychological and emotional harm and neglect, as well as physical and sexual harm. All referrals are considered on their individual merits. In addition to the nature and extent of harm, factors such as a history of or patterns of harm, evidence of intent or a lack of intent, and inexperience or lack of training are relevant to the decision on whether to list an individual. Evidence from the child or children is considered, as is whether the referred individual poses a continuing risk to children.

The DWCL and the Glasgow City Council investigation

16.3 The introduction of the DWCL coincided with the emerging outcomes of the disciplinary proceedings following the Council’s investigation. Thus, from January 2005 the Act conferred upon Glasgow City Council, and other employers in a similar position, a duty to refer to the DWCL any individual it believed had harmed a child, or put a child at risk of harm, and whom the Council had dismissed as a consequence of that belief, or would have dismissed had that individual not resigned, retired, been made redundant or otherwise left the Council’s employment. In addition, the Council could, but was not obliged to, make a referral where the harm or risk of harm occurred and disciplinary action took place prior to the Act coming into force.

Referrals

16.4 Between mid-2005 and mid-2007, records provided by the Council indicate that it referred 30 ex-Kerelaw employees to the DWCL, some of them more than once. By the end of 2008 decisions had been made to list 9 of those individuals and to not list 15. The remaining 6 individuals remain provisionally listed pending the outcome of appeals to the Employment Appeals Tribunal and/or receipt of further information from the Council.

16.5 The Council considered whether a further 6 ex-Kerelaw employees should be referred to the DWCL, but concluded that they did not meet the criteria for referral. Instead, those 6

individuals were only referred to the SSSC, along with 27 of the 30 ex-Kerelaw employees referred to the DWCL. The remaining 3 who had been referred to the DWCL were teachers, 2 of whom were also referred to the GTCS, while the third was already known to the GTCS in this context.

16.6 Concern was expressed to the Inquiry that the first some individuals they knew about a referral was when they received a letter from DWCL officials notifying them that they had been referred. DWCL officials told us that they see it as a key function of their role to contact individuals once they are provisionally listed and to seek their comments on information gathered during the DWCL process, as well as to keep individuals informed of progress. Many of the ex-Kerelaw staff we spoke to were shocked that Glasgow City Council did not always let individuals know they had been referred to the DWCL or why. DWCL officials told us they had been surprised by this lack of contact too, although they acknowledged that it can be hard for an employer to trace an ex-employee.

Timescales

16.7 The time taken between the referral by Glasgow City Council and the DWCL listing decision has varied greatly between individuals. Critical factors in determining the timescales include the availability and quality of information and, crucially in terms of delay, the intervention of other processes such as criminal proceedings, disciplinary proceedings by the SSSC and the GTCS and Tribunals. The need to wait for decisions from the Crown Office and Procurator Fiscal Service on Kerelaw cases was cited as a reason for the delay in the DWCL officials gaining access to information held by Strathclyde Police.

16.8 In the interests of fairness to the individual and so that decisions are made on all relevant information, the DWCL will usually wait until legal proceedings are determined. However, in three Kerelaw cases, with the permission of the individuals concerned, the DWCL Determination Panel did reach a decision before the completion of other proceedings in order to expedite consideration of the cases.

16.9 In some cases, the decision not to list an individual was made quickly – from 3 weeks to a few months after the referral was made. For others, the decision not to list took much longer – for 2 individuals that decision took over 2½ years - a very long time for anyone to bear the uncertainty involved. Similarly, the first decision by the DWCL to list an ex-Kerelaw employee was made within 5 months of the referral while others have taken 1½ - 2 years. All of those who remain provisionally listed have been provisionally listed for at least 2½ years and of these 2 have been provisionally listed for over 3 years.

Handling the referrals

16.10 The coincidence of the launch of the DWCL and the Glasgow City Council's investigation had an early and significant impact, on both the DWCL team and the Council. Both were new to the process and DWCL officials could not have reasonably anticipated the volume or nature of referrals that ensued as a result of the Council's investigation. There was little time for either party to absorb the detail of the process or to build on their understanding of cases before having to deal with more. We were told this was the first time DWCL had received a large batch of referrals at once and the first time they had received cases where the organisation had not undertaken some form of investigation into the allegations.

Nevertheless, the DWCL continued to deal with each case on its individual merits, seeking further information from the Council as necessary.

16.11 We were told that by this time Glasgow City Council had published its report of the investigation, including the assertion that “around 40” people at Kerelaw were involved in abuse. This created some media interest in listing that had to be managed. At this time it was also necessary for the Scottish Government to issue further guidance on provisional listing and individuals working with children while provisionally listed.

Gathering relevant information

16.12 Examination of Glasgow City Council’s DWCL referral files and evidence provided by the DWCL team and the Council suggests that the latter struggled to compile a comprehensive case for many of its referrals. In some cases unsubstantiated and/or uninvestigated allegations – some of them reported by third parties – were used as the basis for an initial referral. Usually at the request of the DWCL, although sometimes proactively, further relevant information was submitted over time. For some referrals, the follow-up information led DWCL officials to consider that the referrals were legislatively incompetent because the referral criteria had not been met and in one case, following an appeal against dismissal an individual had been reinstated. On one further occasion, the Council requested withdrawal of a referral because, on conclusion of their investigation, they decided there was no case to answer on the referred matter. This was a unique situation and was described as potentially very awkward for all concerned. While the DWCL continually pressed for information to meet tight deadlines and maintain momentum, the Council frequently requested more time to gather information, effectively prolonging the consideration process. It was noted too that the Council’s Education Department was, and continues to be, slow off the mark in relation to the teachers referred to the DWCL.

16.13 It was a concern for DWCL officials that many of the Council referrals included very little information and lacked specific dates for when incidents were alleged to have taken place. Also, in some cases the interdependencies between incidents and the referred individuals were unclear. Given that a referred individual would be entitled to comment on the allegations, he or she would in turn expect to be given specific information on which to comment. This led to a sometimes drawn out exchange of correspondence seeking and providing further information and inevitably to delays in the decision making process. This difficulty was discussed between the DWCL and the Council, which expressed concern that disclosure of third-party information to an individual who had been referred to the DWCL – for example the source of evidence against the person concerned - created risks to the safety of children and staff in a small community such as Stevenston. The end result of the discussions was a compromise relying on redacted information.

The competence of referrals

16.14 It is clear that there was also a significant gap in the Council’s understanding of the requirements for a legally competent referral. The DWCL has no investigatory powers and, where an individual was referred to the DWCL after leaving the Council’s employment voluntarily, the Council had to be willing to state that it would have dismissed or would have considered dismissing the individual had he or she remained in its employment. This is a requirement of the 2003 Act. In a number of cases the Council was unwilling to commit to that statement. In explanation we were told by the Council that, “precious as it might seem,”

if an employee has not been investigated, the employer cannot say whether or not it would have dismissed that person. Furthermore, we were told by the Council that it could not investigate allegations against a former employee retrospectively.

16.15 This created something of an impasse in relation to the referral of ex-employees that was raised with the Inquiry by the DWCL officials and the Council. Our consideration of the referral files suggests that this was a factor – although it was not necessarily the deciding factor - in at least 8 decisions by DWCL officials not to provisionally list individuals who had been referred by the Council.

The listing decision

16.16 While the legislation is clear that the final decision to list or to not list is for Scottish Ministers, a number of interviewees from the DWCL case team and Glasgow City Council made it clear to us that there was a belief in the Council that the role of the DWCL was simply to endorse the position taken by the former in making a referral: that is, that a referral would automatically result in listing on the DWCL. This may have stemmed from the direct causal relationship drawn by some in the Council between the culture of abuse at Kerelaw and the culpability of specific members of staff – even where there was a lack of hard evidence for that causal link. As a consequence, there was some debate and disgruntlement as to why DWCL officials should need more information on an individual who had been referred when, so far as the Council was concerned, that individual should be listed.

The Protection of Vulnerable Groups (Scotland) Act 2007

16.17 The picture in relation to the DWCL is far from static and significant developments are under way. The 2003 Act will be repealed in due course by the Protection of Vulnerable Groups (Scotland) Act 2007 (“the 2007 Act”). This will in effect extend the protection of children afforded by the 2003 Act to vulnerable adults and combine listing procedures with vetting and disclosure arrangements, which are currently contained in the Police Act 1997.

16.18 Section 9 of the 2007 Act will make it an offence to fail to refer an individual within 3 months of the duty to refer arising. This will be helpful in the context of tightening the timescale for the referral process, but creates the possibility that the number of rushed and possibly incomplete referrals may increase under pressure. However, the DWCL team did not feel this was a significant issue, noting that by and large the quality of current referrals is good and that the 2007 Act will only require organisations to provide the information that they hold.

16.19 There is specific provision under the 2007 Act for Ministers to require police information to enable or assist them to decide whether to list an individual. There is also provision for Ministers to require public bodies etc to provide information. This should mean better access to information than is currently the case under DWCL.

16.20 Individuals who are under consideration for listing under the Protection of Vulnerable Groups legislation – which has the same effect as provisional listing under the 2003 Act - will continue to be able to work with vulnerable groups pending the listing decision. The Scottish Government was aware of the situation in England and Wales, where those on the provisional list are prevented from working with vulnerable groups, but Scotland has not gone down that route. That decision would appear to be vindicated by a recent House of

Lords ruling that the approach in England and Wales is in contravention of the European Convention on Human Rights (ECHR).

16.21 We were told also that the Protection of Vulnerable Groups arrangements will incorporate continuous vetting of individuals so that where new conviction information or police intelligence or other vetting information arises that is relevant to working with children and/or vulnerable adults, a decision may be taken to place the individual under formal consideration for listing. This will be much better than the existing system, where a disclosure can be out of date on the day after it is issued.

Conclusion

16.22 The referral of ex-Kerelaw staff by Glasgow City Council to the DWCL raised a number of concerns. As the DWCL has no investigatory powers and must rely on information provided by others, the quality of that information is crucial. Not all information provided by the Council was adequate. Moreover, without confirmation that ex-employees who left voluntarily would have been dismissed, or been considered for dismissal, the DWCL would have had to consider the case as legislatively incompetent. Also, some individuals have remained provisionally listed on the DWCL for up to 3 years without a decision. While there are reasons for this, it is in the Inquiry's view an unsatisfactory state of affairs. Although there are apparently not many individuals provisionally listed who continue to work with children, the possibility that someone who is provisionally listed and who may go on to be listed can continue to work with children for a protracted period after referral prolongs the risks in relation to child protection. We therefore welcome the improvements in the protection of children that will derive from the new Protection of Vulnerable Groups legislation.

17. LESSONS LEARNED BY GLASGOW CITY COUNCIL

17.1 The Inquiry was asked to consider the steps taken by Glasgow City Council to safeguard the children it places in residential care following the closure of Kerelaw. We sought information on the lessons learned by the Council in interviews and examined current documents in order to establish those steps.

17.2 In its report to the Minister for Children and Young People in August 2007 Glasgow City Council noted that it had taken action to strengthen safeguarding for children and young people and had developed an Action Plan to address the findings of the Council's investigation into Kerelaw. This has since been developed further.

The Kerelaw Action Plan

17.3 Responsibility for implementing the Kerelaw Action Plan was taken by the Council's Safeguarding Working Group. This group was established following the Edinburgh Inquiry to oversee safeguarding activity and monitor progress at both local and city levels.

17.4 The original Kerelaw Action Plan proposed actions to be taken under 6 broad themes:

- listening to children and young people
- care planning and care management
- external management and monitoring
- personnel processes
- external scrutiny
- use of restraint

and it appears to the Inquiry that progress has been made in each area. Some tasks are complete and others are ongoing, and some further attention from the Council would be of benefit, as outlined below.

17.5 The Inquiry was told that the Kerelaw Action Plan had been subsumed into the Council's overarching Safeguarding Action Plan, and we accept the logic of that, although examination of the two documents suggested that this was not entirely the case, with some elements of the Action Plan having apparently been lost in the process. We therefore asked the Council to update the Plan to show what progress had been made. This showed progress on a range of actions covering listening to children, care planning, staff training in safe care and integrated assessment, the development of practice standards, complaints logging (but see paragraph 17.10 below) and management, external management and scrutiny, and personnel processes.

Delivering the Action Plan commitments

17.6 The city-wide Safeguarding Action Plan overarches 5 locality-based plans, one in each of the Community Health and Care Partnership (CHCP) areas. The most recent version of the city-wide plan seen by the Inquiry was dated July 2008. We also examined 2 local CHCP safeguarding plans, one dated April 2008 and the other undated. We understand these are the most recent updates in a stream of safeguarding activity dating back to February 1998, when the Council began to respond to the 1997 Kent review.

17.7 The city-wide Action Plan is large, and examination of the content suggests many actions are out of date, with no changes since 2007 despite the cover date. The two local action plans which we reviewed address important safeguarding issues, but are “work in progress” at this stage; so delivery is not fully measurable. We were told that Council staff accepted that safeguarding could be improved by better streamlining and more effort on implementation.

Purchased provision

17.8 The Inquiry has concerns that effective quality assurance is more difficult for purchased provision than for provided services and that this may increase the potential risks for accommodated children. In fact, the monitoring of purchased residential places appears to rely on the combined effectiveness of local care management by fieldworkers and central contract management arrangements. In interviews we heard that efforts are being made to ensure fieldworkers recognise their particular responsibilities in this regard and this is to be welcomed. In one CHCP this role is supported by practice guidance for staff on care planning and frequency of contact, and we hope that all are aiming to share and adopt best practice. In this context, the Inquiry welcomes the recent development of a Multi-Agency Resource Group, which has assumed responsibility for the review of quality assurance arrangements and for ensuring that placements for looked after children are appropriate.

Oversight of complaints and allegations

17.9 The Inquiry heard that a number of individuals keep records of one kind or another concerning complaints and/or allegations from looked after children. However, it appears that the Council does not keep one comprehensive central record of this information as was proposed in the Kerelaw Action Plan. Work has been going on for some time on an electronic system which can be integrated with existing information systems but, until that is established, an overview is lacking, which makes it difficult for the Council to “join the dots” in relation to complaints and allegations – a deficiency identified as contributing to the failure to identify abuse at Kerelaw over a period of years.

17.10 It appears that the current approach to monitoring is at odds with the Council’s procedure *Complaints and Allegations – Keeping Children and Young People Safe* dating from 2001 and revised in 2004, which requires the Keeper of the Child Protection Register to log all complaints and allegations centrally, and to report 4-weekly to the Head of Service and annually to the Child Protection Committee. In effect, this means there is no independent scrutiny of complaints and allegations, which potentially undermines the credibility of the formal complaints process and the Council’s wider approach to child protection. While noting that neither HMIE nor SWIA has raised this concern in recent inspections, Glasgow City Council has acknowledged this gap and has committed to implementing the necessary arrangements. On a more positive note, the Inquiry welcomes the annual reporting of complaints and other key areas of performance within provided services which has now been in place since 2007.

The role of the Child Protection Committee

17.11 The Council’s Child Protection Committee was operational throughout the period covered by the Inquiry and has reported annually on its work since 1996-97. We considered a range of material from the Committee and noted few references to Kerelaw, either before or

after the school's closure. This raises questions about the extent to which the Committee took an interest in placements at the school or in the outcomes for young people placed there. While the Inquiry can see why Kerelaw may not have featured heavily prior to 2004 – regrettable though that was – it is hard to understand why it did not appear to take an interest in Kerelaw once problems were recognised. As a minimum, the Committee should have ensured reporting of complaints and allegations took place as provided for in the complaints procedures, and more in the way of scrutiny of safeguarding actions and outcomes might have been expected.

17.12 The Inquiry was told that the Council had recently participated in an HMIE Child Protection Inspection and was expecting a good report from that. However, the self-assessment document used by the Council for that inspection contains no references to the lessons learned from Kerelaw or the strategic and operational issues raised. Nevertheless, the Inquiry welcomes the recent positive examples of scrutiny and reporting activity in relation to provided services. Annual reports are now prepared and published in relation to Glasgow City Council's residential units and the service is developing audit activity and Care Commission monitoring procedures.

Children's Rights Services

17.13 The Council has articulated a *Listening to Children* strategy which seeks to ensure that all agencies and professionals understand their responsibilities to listen to children and to ensure their rights are respected and promoted. Steps have been taken to revise training for fieldworkers to emphasise safeguarding remits and responsibilities.

17.14 The Children's Rights Service has an important role in proofing policies and strategies as well as providing a direct service to the most vulnerable and excluded children, and the Inquiry welcomes the mainstreaming of this service. We note that the service covers a wide range of foster care placements and residential settings and services – often outwith the city – and we were told that the service in Glasgow faces significant pressures as a result. In consequence, we were told, direct one-to-one contact with young people is difficult to sustain. This is a concern, as the quality of relationships young people are able to establish with adults can have an important bearing on their ability and willingness to speak up about worries. This situation echoes concerns expressed by CROs who told us how difficult and time-consuming it was to follow up and take forward specific concerns raised by children at Kerelaw.

17.15 This evidence of significant pressure on the Children's Rights Service raises concerns about resourcing that the Inquiry believes Glasgow City Council should examine. There is moreover a wide variety of purchased and provided advocacy service models across local authorities, which suggests that there may be merit in a national review of best practice in the funding, commissioning and delivery of Children's Rights Services to ensure Scotland maximises quality and value for money.

Wider Strategic Developments in Glasgow City Council

17.16 Senior managers and elected members described to the Inquiry a number of strategic initiatives to recast the approach to children's services in the city. A Corporate Parenting Strategy sets out how the Council and its partners will assume collective responsibility to meet the needs of looked after children. This strategy emphasises the role of elected members

as corporate parents, establishes a Champions Board of elected members and senior officials, and clarifies the role of the corporate management team in monitoring and evaluating outcomes for the Council's looked after children. This perspective was lacking in relation to Kerelaw and the Inquiry welcomes this development.

17.17 We also welcome proposals for implementation that include performance monitoring, quality audit, awareness raising, safeguarding training, service redesign, evidence- and research-based interventions, plus an educational attainment working group, annual reporting in relation to looked after and accommodated young people, engagement of children and young people and the involvement of the Multi-Agency Resources Group.

17.18 The Inquiry recognises the work undertaken so far on new strategic planning and service development. However, the challenge for the Council will be to bring about change in how managers and front line workers do their jobs and turn strategic priorities into measurably better outcomes for children. From previous Inquiries and in our own work, it is evident that strategies and policies, while important, are insufficient in themselves to effect change. The Council had numerous policy documents, codes and guidelines throughout the 1990s that did not adequately safeguard young people at Kerelaw. Effective implementation and management of compliance together with clear accountabilities throughout the management line are the key to adequate safeguarding.

External management of provided residential provision

17.19 As discussed at paragraphs 13.10-13.27, weaknesses in external management contributed to the problems at Kerelaw. The Council has restructured the external management arrangements for provided residential child care since Kerelaw closed, so that the number of external managers - which was set at 9 (8 plus a Principal Officer) in early 2002 - has been reduced to 5 posts, plus a Principal Officer. While it was explained to us that this was to provide one per CHCP, allowing the disaggregation of external management to CHCP level, a number of those who gave evidence to the Inquiry considered this reduction in numbers inconsistent with the "strengthening" of external management alluded to in the Glasgow Report. This may be a signal that the Council needs to take soundings from the front line and review the new arrangements.

Impact of Kerelaw on contemporary practice

17.20 The Inquiry met two focus groups – one of residential unit managers and one of social workers who had placed young people in Kerelaw in the past - with a view to gaining an external perspective on Kerelaw and an insight into the lessons learned by the Council following events there. Residential workers told us they believed the situation had evolved over several years of neglect and that it seemed Kerelaw had not been seen as fully part of Glasgow City Council, having been considered by many as discrete and different. We were told that Kerelaw has had a lasting legacy in the Council. Some spoke of a culture of fear among residential staff. They were said to be the group most acutely aware of the importance of safe care, yet they felt the most vulnerable to allegations and scrutiny.

17.21 We heard that a legacy of Kerelaw was that, despite national guidelines in *Holding Safely* and internal policy on the use of TCI, staff were fearful that if they exercised restraint in any circumstances they were vulnerable to disciplinary action. This stems from the premise that almost any circumstances could be construed as circumstances in which physical

restraint was not advised, leaving staff open to challenge on every occasion. It is important that employers recognise their responsibility both for ensuring that residential child care workers are not left in any doubt about where they stand in relation to the use of physical restraint and also for reinforcing that position over time.

17.22 Unit managers told us that they now have much clearer lines of accountability with clear expectations in relation to safe care. Units all have safe care plans which they review regularly with external managers. Monthly audits of care plans are standard practice, and unit managers now expect spot checks, unannounced visits, and scrutiny by external management. A number of returns are required by HQ. All of this was seen as positive, but unit managers stated that the service was stretched and continued to feel that some senior managers have not always understood the dynamic of external management or the need to balance scrutiny with support. They did, however, feel that the balance was improving.

17.23 Unit managers noted there have also been improvements in recruitment through the introduction of assessment centres, although they were concerned that recent attempts to implement a corporate approach linked to a shared service centre could undermine progress achieved by social work services in taking into account applicants' values and attitudes. They believed that the proposed changes were too rigid and competence-focused.

17.24 Residential staff told the Inquiry that there is evidence of more contact between young people in residential care and fieldworkers and more awareness of safe care issues. This was attributed to training and briefings in relation to lessons learned from Kerelaw. However, there were still concerns about the adequacy of placement planning for young people and there are still capacity issues which mean that service aspirations may not be met in full.

17.25 Residential staff believe there is evidence of the complaints system being used in Glasgow City Council units by young people, who were described as being more confident about raising concerns. Unit managers said this was reflected in the relatively high levels of fact-finding investigations they were asked to undertake. Staff spoke about investigations often taking months rather than weeks and, as suspended workers were not replaced, this put pressure on others and had an impact on the work of the unit. There was concern that this additional pressure was not appreciated fully by senior managers.

17.26 There was some criticism of the HR and administrative support which was available, and a variety of concerns, which would be familiar in any organisation, about employment law and the pressures which flow from being involved with disciplinary processes. It is important that central HR and administrative services accord appropriate priority in their own work to ensure that unnecessary delays are avoided. It is sometimes too easily overlooked that delays in fact-finding and disciplinary processes can exact a heavy toll both on service provision and on the individuals who are under investigation.

17.27 Unit managers commented on working with the most challenging children since Kerelaw closed. They now require to deal with problems themselves and can no longer rely on transferring responsibility to Kerelaw on an emergency basis. This is a significant change, but one which we were told is being managed with reasonable success.

17.28 We were told that supervision continued to be a priority for staff, who told us they did have regular supervision, and that it was minuted and focused. However, there was a consensus that supervision could often be the first thing to be abandoned during a crisis,

although some unit managers were said to be very creative and had used group supervision for shifts during significant events. Staff told us that Residential Services Managers sampled the supervision notes from their units and that the Care Commission also looked at the notes during inspections.

17.29 We were also told that the introduction of a Code of Conduct for residential workers which was produced in 1998 and updated in 2004, to reflect new structures, had been important in changing the culture. There were positive references to residential care having tried to move on and promote safe care priorities. Encouragingly, there was talk of a reflective self-evaluation culture beginning to develop and drive change. The Inquiry welcomes these positive signals and the arrangements the Council told us they have put in place to monitor, support and, where necessary, challenge contemporary practice.

Conclusion

17.30 Many senior management changes have taken place in Glasgow City Council since Kerelaw closed and a number of strategic and operational initiatives have been developed to improve the safeguarding of looked after and accommodated children. Lessons appear to have been learned from what went wrong in relation to Kerelaw. Action plan commitments have been taken forward as part of a wider safeguarding agenda. The Inquiry concluded that there is scope for more effective and better coordinated implementation in some areas, including quality assurance and monitoring of purchased provision, capacity building within fieldwork services, and complaints procedures, including the monitoring role of the Child Protection Committee. The Inquiry had concerns about the capacity of the Children's Rights Service in Glasgow. We also concluded that wider consultation and communication within the Council on the revised external management arrangements would be beneficial. Strategic priorities and new policies and procedures must now be fully operationalised in working practices and management accountability, from the bottom to the top of the management line.

18. ANALYSIS AND CONCLUSIONS

Did abuse take place on the scale suggested by Glasgow City Council?

18.1 The Inquiry believes that abuse of young people did take place at Kerelaw after 1996. Court convictions and the records of disciplinary action taken by Glasgow City Council point to abuse having taken place over a number of years before then as well. The Inquiry found no grounds for concluding that sexual abuse was widespread or institutional, but cannot rule out that sexual misconduct took place to a greater extent than has been proven and is in the public domain. To say it cannot be ruled out is not to imply that it must have happened. We believe that to draw an inference from Glasgow City Council's report on its investigations that 40 staff might have been involved in sexual abuse over a lengthy period, and that a much larger number knew about it and did nothing, would not be justified.

18.2 The position as regards physical and emotional abuse is complex. By no means all staff engaged in such activity. There were good and dedicated staff who worked hard for young people. Many young people testified to that, and said that they had a positive experience at Kerelaw. The Inquiry considers nonetheless that physical and emotional abuse did take place over a period and was associated mainly with a particular core of staff. Although their practice gave cause for concern to some of their colleagues, it went largely unchecked until brought into the open in 2004, when the investigation of allegations of bullying and harassment of staff against the manager of the Millerston Unit was put in hand. It is regrettable that it was staff complaining about their own treatment, rather than the treatment of young people, which led to the fact-finding that then uncovered allegations by residents and ex-residents of ill treatment and abuse.

18.3 Physical abuse took a number of forms: poor practice; inadvertently clumsy restraints; deliberately painful restraints masquerading as consistent with approved procedures; and common assaults which owed nothing to guidelines, procedures or acceptable behaviour. Emotional abuse included threatening behaviour towards young people, shouting and swearing, and the use against them of their own life histories to disparage, devalue and among other things discourage complaints.

18.4 Those who physically abused young people will not have done so all the time, and some will no doubt have believed that what they were doing was not abuse, or was justified by the behaviour of young people they faced on a daily basis. For some, what became recognised as abuse in later years might not have been considered abuse when they first began working in residential child care. Nevertheless, it was abuse and should not have occurred.

18.5 We do not consider that the outpouring of allegations made to investigators in 2004 and 2005 can be explained away on the grounds that residents and former residents saw the investigations as an opportunity to win compensation. It is possible that a desire for compensation may have been a factor in some allegations, but the statistics for those who have submitted claims do not suggest that this was a significant motivator. Most of the claims for compensation were lodged after the outcome of the trial of the teacher and manager in 2006, and only a small number of those interviewed by Council investigators had made claims by the end of March 2009.

The circumstances that led to the abuse

Culture

18.6 The circumstances in which abuse was able to take place reflect a complex mix of factors, of which culture was particularly important. An emphasis on control, and the physical capacity to enforce it, originating in Kerelaw's history, lived on longer in a workforce which was heavily drawn from the surrounding local communities than it might have done in a wider labour pool with less of a tendency to close ranks round shared attitudes and behaviours. Ties from familial and other relationships reinforced this tendency.

18.7 The cliques and loyalties associated with those relationships were intimidating to staff who were concerned about what they saw, and were therefore a disincentive to challenge or whistleblow, although eventually some staff overcame their hesitations and spoke up. Many, however, did not, or left rather than report colleagues.

18.8 Differences and rivalries reduced the effectiveness of the senior management team, and made the pursuit, far less the achievement, of cultural change unlikely. The regular changes in senior management after 1996 also predisposed against any sustained attempt to challenge existing practice and bring about new approaches. The leadership based on shared values and clear vision which staff should have been given by their senior managers was largely absent. The opportunity to bring about change was lost in senior management churn.

Capacity for change

18.9 There was limited capacity for change within Kerelaw. Some senior people understood the need to challenge the prevailing culture and there were attempts at change, but these either failed to gain traction or ran out of steam. Two individuals at different times recognised that change was needed. Such aspirations as there were to bring about a more inclusive culture in which people put aside rivalries and worked more constructively together came to nothing.

18.10 The appointment from outside Kerelaw of a Principal with a potentially different perspective was an opportunity for change. The period from late 1998 to the end of 2000 was one of some change and modest improvement. Resistance to change from some staff and managers was evident but, with time, training, and probably changes among senior managers and some residential staff and teachers, lasting improvements might have been achieved. It is, however, difficult to say. Tentative steps towards a different, more inclusive culture, fit for a new, redeveloped Kerelaw, with a shared vision supported by management development and training, and by regular supervision, monitoring and accountability, were not sustained after his departure.

Training and development

18.11 Many staff came to Kerelaw without any prior training, although some others arrived already professionally qualified. Over the years, training developed in the residential sector, in which Kerelaw participated successfully in that many staff obtained qualifications. For some the learning was important and led them to consider their practice. However, the potential of this was never fully realised at Kerelaw. The Inquiry considers that the main reasons for this were the lack of a consistent or sustained overall shared vision for Kerelaw to

which learning and development should have been linked, and a lack of process for embedding new learning and assisting staff to put their training into practice. There was also a resistance on the part of some individuals to learning new approaches stemming from a belief that no-one outside really understood their task.

18.12 Weaknesses in training for TCI contributed to poor practice, which was often abusive. How to restrain, as opposed to how to avoid having to restrain, appears to have been over-emphasised. Insufficient attention was paid to refresher training, which would have picked up developments in the system and misunderstandings by staff, until 2003, by which time some staff had received no updated training for 6 or 7 years. This meant that an over-emphasis on physical control was not challenged, and it reduced the ability of staff to respond safely to the increasing pressures they were facing from the client group.

Poor supervision and lack of performance management

18.13 There was no effective system of performance management or appraisal in relation to Kerelaw which would have required the senior management team to agree clear individual objectives and accountabilities with the Principal, or which would have required the latter to sit down with the Head of Service and agree what was expected of him. It meant that there was no real framework which required the Principal and his line manager to review formally the former's performance against agreed plans.

18.14 All care managers and staff should, however, have been subject to a formal system of supervision, familiar to social work practitioners, designed to support staff and enable practice to be reviewed and improved. This was inadequately applied. Successive inspection reports and reviews found it deficient and, although the need for improvement was recognised, and some improvements introduced, supervision took place inconsistently and was of variable quality. Failures in supervision played an important part in what went wrong at Kerelaw.

Complaints system

18.15 Although some complaints by residents were followed up rigorously when external placing authorities were involved, the complaints system was less than effective when kept in-house. While many of the outward manifestations of a complaints system were present, inspection reports regularly raised concerns about record-keeping and feedback. Many young people had no idea that complaints could be made outside the school and that the Principal was not the final arbiter. In some cases it was not clear to young people that complaints could go beyond their residential unit manager.

18.16 There were significant disincentives to young people to complain. Some saw no point because they received no feedback. Some were reluctant to make complaints in case staff lost their jobs. Some even seem to have accepted a level of violence against them as a normal part of the lives they led both in and outside Kerelaw. Some thought they brought it on themselves. Others were intimidated by their peers not to make complaints in case treats were withdrawn. Still others were told by staff that no one would believe them because of their history and behaviour. In short, the complaints system did not work adequately at the front end – the complainer, or at the back end – the follow-up stage.

Inspection

18.17 Inspection did not stimulate culture change at Kerelaw. This is not surprising. HMIE appear not to have inspected the Open School for 17 years after 1984. There was insufficient coordination of inspection, with HMIE, SWSI and North Ayrshire Council all involved. Only North Ayrshire Council in its inspections until 2002, when the Care Commission took over, gained a regular overview of Kerelaw as a whole. Over the years North Ayrshire Council raised a number of concerns, although not to the point of advocating closure of the school. All 3 inspection agencies gave credit where it was due – and it was due in a number of regards – but they were also clear that improvement was required. However, the common features of inspection activity until after 2003 were insufficient, consistent follow-up within Kerelaw and insufficient attention from external management.

18.18 The inspections of Kerelaw resulted in mixed reports over the years. Good points were highlighted and progress noted. However, far from indicating there were no problems, reports consistently raised concerns about staffing levels, the state of the buildings, lack of supervision, poor record-keeping, particularly in relation to complaints, and care staff-education staff interactions. Some concerns and criticisms expressed privately among inspectors did not find their way into published reports. There is some evidence of engagement by senior Social Work Department managers in receiving feedback and in following up recommendations, but follow-through was extremely poor. Little consistent interest appears to have been taken by the Council's Education Department in HMIE findings.

18.19 It is not justified to contend, as some have, that the poor report of the repeat inspection carried out by HMIE and the Care Commission in August 2004 was a bolt from the blue. The integrated HMIE/Care Commission inspection in November 2003 which preceded it raised a number of serious concerns, including deficiencies in the follow-up to a report of an inspection of the Open School carried out by HMIE over 2 years earlier, in September 2001. A number of those concerns were around issues that had come up on more than one occasion over the years. Internal papers from the Summer of 2004 suggest that individuals in the Care Commission had for some time harboured serious reservations about how Kerelaw was being run, yet there was no indication as to the seriousness of these in the report on the November 2003 inspection carried out jointly with HMIE.

18.20 Our overall conclusion, like that of other reports, is that inspection alone cannot be relied upon to bring about change and improvement. Even where problems and concerns are identified, and it is for consideration whether inspection methodologies are sufficiently tuned to allow cultural inferences to be drawn, only appropriate follow-up and management action can bring about improvements. Both internal and external management at Kerelaw failed in that respect.

Glasgow City Council's stewardship of Kerelaw School

Local government reorganisation

18.21 There were serious deficiencies in the internal management of Kerelaw over the years, but they alone do not explain why things went so badly wrong. If for many residents the stewardship of Glasgow City Council was inadequate, the same might be said for the employees of Kerelaw also. The transition from Strathclyde Regional Council to Glasgow

City Council ownership was not an easy one. Personnel had to be matched to posts in the new Council and many people left. To deal with this and the budgetary dilemmas which the Council faced, recruitment was frozen and this had an effect on Kerelaw. A number of staff had to remain on temporary contracts for a long time, and some simply left when permanent opportunities arose elsewhere.

18.22 The migration to new systems was not straightforward and Kerelaw had simply to get on with the job. Although there was in due course a relaxation in restrictions on recruitment to residential homes, it took considerable time for staff to be given new contracts of employment at Kerelaw. The uncertainty that entailed would have meant staff did not feel valued. Despite observations by Inspectors and concern on the part of Kerelaw management it took 4 years for the contractual position of all staff to be resolved.

18.23 Budgets were a constant problem. The minutes of senior management meetings in the Social Work Department show the extent to which budgets occupied management time week after week and month after month. This will have made it harder to give the close attention to front-line services such as Kerelaw than might otherwise have been the case. Many services were cut, experienced staff were lost, and social workers were difficult to recruit. In those extremely difficult financial circumstances, there was no appetite for investment or spend to save. Successive Kerelaw managers had to fight for money to improve facilities, fund staff, and establish programmes for young people. Moreover, as Glasgow City Council had an interest in maintaining Kerelaw as a low-cost residential facility by comparison with other providers, winning an increase in budget would have been doubly problematic.

External management

18.24 Kerelaw could not be ignored, but it did not receive from external management the attention that it should have had. Other priorities and heavy workloads meant that external managers had difficulty establishing or maintaining the physical presence at Kerelaw that was required. Kerelaw managers for their part were at best ambivalent about, and at worst resistant to, more involvement by Glasgow City Council or indeed scrutiny by external agencies or individuals. The long-embedded inclination of Kerelaw to distance itself from many of the managing authority's policies and procedures and "do its own thing" should not have been condoned.

18.25 It is difficult to escape the conclusion that Glasgow City Council did not regard putting effort into managing Kerelaw as a high priority. External management responsibility was delegated inappropriately to individuals at a lower grade than the Principal of Kerelaw, and this was bound to be a problem with an institution that was sensitised to "outside interference". This took on more importance from 2001 onwards. While, in less challenging circumstances, and with regular supervision by the Head of Service, this would not necessarily have been unworkable, it was not an arrangement which encouraged proper partnership working between local management and Council HQ. The role of the external manager in determining admissions also created tension.

18.26 In summary, external management was insufficiently resourced, insufficiently senior, and insufficiently visible at Kerelaw to do its job. Its failures were an important contributor to what went wrong.

18.27 These failures were compounded by a dependency on Kerelaw as a placement of last resort for certain young people, which would probably have militated against radical measures by Social Work HQ. But even if external managers had wished to be more proactive, the culture in the Social Work Department would not have encouraged them to share with colleagues the kind of problems which Kerelaw posed. While different Directors of Social Work took different approaches to the resolution of conflict at senior level within their Department, the picture which emerges is of disagreement over policies, priorities, budgets and spending control. In those circumstances the exposure to colleagues of operational problems or of a need for help would not have been easy. The temptation “to let sleeping dogs lie” must have been strong.

Redevelopment

18.28 After the publication of *A Secure Remedy* in 1996, Glasgow City Council engaged in a protracted negotiation with central government over who would pay for a new Kerelaw, based, as it was intended to be, on a Secure Unit serving national needs with some form of close support units around it. Given the budget problems faced by the Council from 1996, it is not surprising that cost would be a major issue, and both sides would no doubt be determined to put as little of their own money as possible into the project. Eventually, agreement was reached on a central government contribution to the cost, some 7 years after Kerelaw’s secure facilities had effectively been declared unfit for purpose. It is hard to escape the conclusion that, with a major redevelopment in view on an albeit distant horizon, there was no great incentive to the Council to make the investment in buildings or in human resources that Kerelaw required. However, the Inquiry found little documentary evidence to that effect, and any conclusion that it was an important factor would be speculation.

The arrangements for children who were placed in and accepted by Kerelaw

18.29 The arrangements for placing children at Kerelaw and the planning for them when they were there left much to be desired. Although there were procedures for planned admissions to Kerelaw, many took place on an emergency basis. Placements were not always matched to needs, and in some cases were inappropriate. This reinforced the view of many Kerelaw workers that it was a dumping ground for young people with particular problems or who had “failed” in other placements. With so many children placed on an emergency basis social workers had little opportunity for care planning prior to admission. In a number of case files the recording was so poor it was impossible to establish the frequency of contact between the fieldworker and the young person. Nor was it always clear what work was being carried out. Kerelaw files which were reviewed contained a range of care planning materials, and recorded information on children’s progress, but there was little sense of joint working between the placing social worker and Kerelaw staff. There were also weaknesses at the end of placements, with little in the way of effective throughcare work taking place. Our conclusion is there were significant weaknesses in the arrangements for children who were placed in, and accepted at, Kerelaw.

Investigations and disciplinary process

18.30 The presentation in June 2004 to the Directors of Social Work and Education of the report containing the outcome of the Millerston investigation and other material collated over a period of several months produced a strong reaction. The Council clearly decided that it could leave no stone unturned within Kerelaw in establishing what had happened and in

bringing perpetrators to book. The joint investigation team which was put in place faced a formidable challenge. While there was experience within the team of individual fact-findings, and of child protection, no-one had been involved in an investigation of such a scale before. As the team began its work alongside a police investigation into allegations of sexual abuse, it had a sense of moving into uncharted waters.

18.31 Aware of the personal relationships and other issues at Kerelaw identified in the June report, and with a belief that young people had been let down at the front of their minds, the team pursued their investigations with vigour. As allegations involving the same names which had come up time and again over the years multiplied, and as the team itself encountered the personal loyalties and connections which appeared to have hampered previous fact-findings, its determination not to be deflected resulted in an aggressive pursuit of evidence which left many staff feeling intimidated and devalued. While in the circumstances the end may well be thought to have justified the means, for many of those being investigated the presumption of innocence until proven guilty seems to have been lost along the way. As a result, a large number of staff who were not found to have a case to answer, including some who had themselves spoken out against abuse, considered that they had in turn been abused, by the process.

18.32 The joint social work-education investigation started with concerns for child protection, but it was in fact a disciplinary investigation. The scale and complexity of the task were evidenced by the expansion of the team in early 2005 and the length of time it took to complete its work. Despite the complexity, and the wish to proceed without undue delay to disciplinary action, more care should have been taken to quality control the recording of statements, to check available records, names and dates, and to pull together reliable written evidence. More care should also have been taken to abide by the Council's own procedures in respect of making available relevant written information to staff and their representatives. Disciplinary hearings should not have been scrabbling around for evidential productions on the day. The Inquiry also had some concerns that the investigation was not as all-embracing as it should have been between education and social work.

18.33 The Inquiry was left with the feeling that differences in the team between those who felt that in some cases they were dealing with poor practice rather than deliberate abuse were never fully resolved. It would perhaps have been helpful if more senior management guidance had been provided. It seems also that the investigation team might have been better supported by corporate HR and legal services. While we found no evidence of overt pressure on team members from elected members or senior managers to amass enough evidence to dismiss staff, it is not difficult to imagine in the circumstances an unspoken agenda to ensure that the Council could not be accused of being soft on child abuse. It would not be beyond imagining either that the Council would have wished to be seen to hold senior management at Kerelaw to account as well as more junior staff. However, the withdrawal by the Council of two cases being defended at Employment Appeals Tribunals because of admitted weaknesses in processes, and the loss of two actions, raises questions about the quality of scrutiny and advice.

18.34 The Inquiry does not believe that the Council took as much care to keep in touch with suspended employees as it should have done, to comply with its own procedures. The numbers involved may have been a factor, but too many people were kept in a state of uncertainty for too long. The impact of suspension and discipline procedures on the wellbeing of individuals and their families should not be underestimated. Employees facing allegations

about their conduct in relation to young people in their care will feel anxious and may also experience fear, anger, sadness, resentment and hostility. It is incumbent on their employer to keep them informed throughout the process and to provide appropriate support. The Inquiry considers that the Council fell short of meeting its obligations in that regard. The Inquiry also considers that the members of the investigation team should have had formal debriefing by managers following the completion of their work.

Support for young people

18.35 The Council did not adequately anticipate or plan for the support needs of ex residents who gave evidence to the police and/or the joint investigation team. Although Barnardo's were commissioned late in the day to provide support to those who were involved in the Court process, some were over the age limit of 25 and were ineligible for the service. The investigation team was left to arrange for such support as was required for others. This was inappropriate. The Inquiry considers that independent, easily accessible support should have been built into the process. The Council should also have considered the support needs of the wider group of residents who had been in Kerelaw over the years. The Inquiry accepts this would have been a significant piece of work, but found no evidence that it had been considered.

Record-keeping

18.36 The Inquiry believes it is important to reflect on the quality of information provided by Glasgow City Council and on the keeping of that information. We acknowledge that maintaining records in good order when two simultaneous investigations were under way must have had its challenges and that certain information might be held elsewhere while a Court Appeal and various Employment Appeals Tribunals were in hand. Nevertheless, we were concerned about the Council's inability to furnish the Inquiry with complete and accurate records relating to the people at Kerelaw – in particular the residents, but also the staff. This undermines confidence that the Council has improved in its attention to record-keeping in relation to complaints, allegations and other incidents in residential child care establishments.

Leadership and management failure

18.37 There were significant changes in legislation and policy in residential child care in the 1990s. These changes required residential child care staff to gain new knowledge and adopt new approaches to working with the children in their care, and should have been the driver for a major programme of culture change at Kerelaw. The absence of a sustained drive for culture change, the poor follow-up of inspection reports and fact-findings over a long period, inadequate attention to supervision, weak systems, a lack of rigour in monitoring key indicators, and a reluctance to take difficult decisions involving key staff, point to leadership and management failures both within Kerelaw and in Glasgow City Council from 1996. At local level those failures were not helped by lack of continuity in the SMT. But they also reflect a lack of insight into what was required.

18.38 The failures identified relate not only to the period leading up to the events which unfolded in 2004. There appears to have been over the years no shared vision of the future, either within the SMT at Kerelaw or within external management in the Council's Social Work Department. Although the Council was having to adjust to new regulation, we found no

evidence of drive to ensure that Kerelaw was moving with the times. Too much faith appears to have been vested in local management's capacity to appreciate what was required and to respond.

18.39 Kerelaw's flaws came to a head after 2001, when the pressure from an older, more challenging population of residents began to build. A more imaginative response by internal and external managers to the consequences of that would have included a thorough review of Kerelaw's fitness for the role it was expected to discharge and a willingness on the part of Social Work Department management to address concerns about the capacity of local management to bring about the change that was required.

18.40 While it is frequently a challenge to achieve the appropriate balance between empowering well-paid, qualified individuals to get on with their jobs, and the oversight necessary for accountability and compliance with corporate policies, there was too great a willingness to defer to the autonomy of local management. There was systemic failure over a long period to ensure that policies, procedures and guidance were being implemented at Kerelaw. The will to follow through appears to have been lacking. Although individual Heads of Service followed up a number of specific issues over the years, lack of clarity as to what was expected of the Principal of Kerelaw, and over-delegation of external management resulted in a woeful lack of performance management by the Social Work Department in terms of holding senior Kerelaw managers to account.

DWCL

18.41 The referral of ex-Kerelaw staff by Glasgow City Council to the DWCL raises a number of concerns which have implications for child protection and the rights of referred individuals. These concerns relate to: the quality and quantity of information on which the Council's referrals initially were based; the referral of ex-employees on the basis of uninvestigated allegations and the Council's unwillingness to confirm in the absence of an investigation that it would have considered dismissal had it investigated at the time; and the length of time it has, and is, taking to conclude on referrals.

18.42 It was difficult for DWCL officials to process referrals quickly with incomplete information. While the Council's child protection intentions were sound, if consideration had been given to completing its investigations before making a referral the whole picture, including any interdependencies between individuals, would have been made available at once. This would have distinguished between witnesses and those who needed to be referred, and it would have avoided double referrals.

18.43 As the DWCL has no investigatory powers and must rely on information provided by others, the quality of information is crucial. Where an ex-employee has left voluntarily, the legislation requires the ex-employer to confirm that he or she would have dismissed, or considered dismissing, an individual had he or she been investigated and the allegation proved at the time. Without that confirmation, the DWCL has no alternative but to treat a referral as legislatively incompetent under the Act. That raises obvious risks in relation to child protection. A lengthy provisional listing without an investigation or clarity in relation to the allegations also raises concerns in relation to the rights and employability of referred individuals. In guidance issued in January 2008, the DWCL made clear that an ex-employer should consider whether the tests for competence of a referral would have been met if the incident had been investigated at the time.

18.44 Some individuals referred by Glasgow City Council have remained provisionally listed on the DWCL for 2 and sometimes 3 years without a decision about their unsuitability to work with children. This is in the Inquiry's view an unsatisfactory state of affairs. Most often extensive delays have resulted from the intervention of other proceedings, such as Court cases and Employment Appeals Tribunals, where the DWCL waits for an outcome before taking forward its listing consideration. We were told that there are not many individuals provisionally listed who continue to work with children, even though they are able to do so. Nevertheless, the possibility that someone who is provisionally listed and who may go on to be listed can continue to work with children for a protracted period after referral prolongs the risks in relation to child protection.

18.45 The Inquiry was told that, under the Protection of Vulnerable Groups legislation, individuals might be considered, on a case-by-case basis, for listing more quickly without awaiting the outcome of legal or disciplinary proceedings. We welcome the improvements in the protection of children that will derive from the new legislation. However, this is not an opportunity for complacency – the onus will remain on the employer to maintain good records of allegations, complaints and incidents involving individual staff, and on the employer or ex-employer to be efficient in the investigation of such matters. Such investigation will lead to delays in some cases, and it is important that the employer makes efforts to keep individual employees informed about progress during that time and remains vigilant to the risks that remain while those who are provisionally listed may continue to work with children.

19. RECOMMENDATIONS

19.1 The terms of reference asked the Inquiry to make recommendations relevant to ensuring that the contributory factors which led to abuse at Kerelaw occurring and not being acted on for a protracted period cannot happen again. Kerelaw has closed, and the particular combination of history, geography, function, size, and stewardship which contributed to the circumstances in which abuse took place may not recur. Moreover, there have been important changes in regulation in the past decade or more, and further changes are planned. Inspection arrangements are now backed with powers of enforcement. We do not consider that further legislative or regulatory provisions are needed to prevent a Kerelaw happening again, or that they would necessarily do so.

19.2 However, there is no room for complacency, and there can be no guarantees. The unpalatable fact is that most of the factors which contributed to what went wrong at Kerelaw have been identified by Inquiries into child abuse time and again over the years, whether in residential establishments or elsewhere. Recommendations have been made in relation to regulation, recruitment, management, training, supervision, scrutiny, resourcing, systems, policies and procedures which stretch to many pages of print. We could repeat most of them here but do not intend to do so. Nor is it within the Inquiry's remit to make recommendations about residential child care practice on a wider scale. The NRCCI is the appropriate vehicle for that.

19.3 The main failings at Kerelaw were not so much to do with legislation, policies or procedures, of which there was no shortage, as with people failing to comply with those procedures, failing to give leadership and direction, failing to deal with difficult management issues of which they were aware, and failing to care as they should have about disadvantaged, difficult and vulnerable young people with whose welfare they were entrusted. The failings were not confined to Kerelaw. As senior managers in Glasgow City Council struggled with the financial consequences of local government reorganisation, balancing budgets, and internal strife, attention was diverted from a staff and client group who were for much of the time out of sight and out of mind.

19.4 Perhaps the most important recommendation the Inquiry can make is one that reflects the key message from past failures: that those who carry responsibility for the welfare of others must always put the client first and simply do their jobs. However, to support care workers and managers in their task, and to safeguard children in their care, we also make the following recommendations, which we acknowledge include much that is already recognised as good residential practice and part of current National Care Standards. Most of the recommendations are addressed to residential child care providers, by which we mean all providers, whether local authority, voluntary or independent.

Leadership and management

19.5 In appointing senior managers of residential units, providers of residential child care should take into account candidates' leadership qualities as well as their professional competences and experience.

19.6 Providers should ensure that senior managers of residential units fully understand the corporate and organisational priorities and procedures and are clear as to their accountabilities for compliance. This should include formal responsibility for monitoring

violent incidents and complaints and for quality control over statistics provided to the managing authority or board.

19.7 A clear understanding of the key roles and responsibilities of the external manager must be embedded within all residential child care provision. Local authorities who commission such provision should ensure that well established links are forged with the external manager.

19.8 Providers of residential child care should maintain, so far as possible, reasonable continuity in external management, and in senior management teams in residential units, and should plan ahead to ensure that there is an appropriately skilled pool of candidates to fill vacancies when they arise.

19.9 Providers should ensure that external management is adequately resourced to fulfil all aspects of their responsibilities, as set out in Volume 2 of The Children (Scotland) Act 1995 Regulations and Guidance, and that postholders have a clear understanding of their dual role of challenge and support to local residential unit management.

19.10 In line with recommendations in the report of the Edinburgh Inquiry, providers should ensure that external managers have sufficient opportunity to visit residential units, be recognised by staff and residents, and talk to young people in their living areas.

19.11 Providers should review their external management arrangements in the light of this Inquiry. Glasgow City Council should review its recently introduced arrangements for the external management of residential children's units in consultation with those working for their services.

Performance management and appraisal

19.12 Providers should ensure all heads of residential units have a personal performance plan for the year ahead covering organisational and personal objectives, including development objectives, and accountability for the performance management of those reporting directly to them. The plan should be agreed in advance with the external manager and performance reviewed in a face-to-face discussion with the external manager at least twice a year. This management review should be in addition to any professional practice-related supervision which may also take place.

19.13 Providers should ensure that other senior residential unit managers should have a similar plan, agreed by the head of the unit, and reviewed by him or her in a face-to-face discussion at least twice a year. Plans should include the number and frequency of supervision sessions to be carried out with staff who report to them.

19.14 The external manager should also have a performance plan, which should include targets for the number of visits to residential units to be achieved, and in which his or her accountability for the face-to-face performance review of the head of the residential unit should be explicit.

19.15 Providers of residential child care should consider whether the transparency and supportiveness of performance management might be enhanced by the introduction of peer review and 360 degree appraisal processes. This should include feedback from peers, residents and agencies using the service.

Supervision

19.16 Providers of residential child care should develop and implement a supervision policy which is based on regular, planned and recorded supervision sessions between all grades of staff and their line managers up through the management chain.

19.17 In addition, in order to promote group learning, consideration should be given to introducing shift or other forms of group supervision.

19.18 Supervision should include 3 core elements: performance management; staff development; and staff support - as suggested in the *Report of the 21st Century Social Work Review (Changing Lives)* in 2006.

Training and learning

19.19 Where training or learning is offered by the provider to support new policies or new working practices, managers and staff should, wherever possible, be given the opportunity to train alongside staff from other residential units and fieldworkers.

19.20 Training should supplement and support, not be a substitute for, communication and leadership by senior managers.

19.21 External managers and heads of unit should use the twice-yearly performance review discussions to evaluate, from the perspective of the individual and the organisation, the benefits of any new learning which has taken place.

19.22 Unit managers should use supervision with staff as an opportunity for similar evaluation of new learning.

19.23 We welcome the requirement for the registration of residential child care workers with the SSSC, and agree with SIRCC that the baseline registration qualifications should require relevant content to the correct academic standard.

19.24 Providers of residential child care services should ensure that sufficient resources are available for managers and staff to enable them to advance their professional development and inform their practice in line with SSSC registration requirements.

19.25 Providers should ensure that training in crisis intervention, such as Therapeutic Crisis Intervention, is refreshed regularly as prescribed in the relevant instructional literature, and uptake monitored. External and internal managers must continually reinforce that Therapeutic Crisis Intervention is first and foremost an option for de-escalation and not for restraint.

19.26 Providers should ensure that residential care staff fully understand the circumstances in which physical restraint may be employed so that staff feel confident that they will be supported by management when they act appropriately. Staff should also be aware that if, following assessment of the context, they are deemed to have acted inappropriately they will be held accountable.

Listening to children

19.27 Providers of residential child care should make their complaints process easily accessible to all young people placed with them, and should assist them to differentiate between a non-criminal complaint and an allegation of abuse. The procedure should not be dependent on completing a complaints form. Other options for communicating complaints and concerns should be offered: for example, using information and communications technology.

19.28 External managers of residential units should review with the head of unit, at least quarterly, a record of complaints and allegations over the previous period, noting any trends or patterns.

19.29 Providers of residential child care should maintain a central log of complaints and allegations and their outcomes, and incident reports, which should be reviewed regularly by senior managers and made available to the Care Commission during their inspection visits. The log should include an analysis of the nature of the complaints, allegations and incidents, and how they were resolved, and the young people and staff members involved.

19.30 Providers should ensure that scrutiny of complaints and allegations for all their services for children within a residential child care setting is subject to appropriate professional review outwith the line management structure. Similarly, purchasers of residential child care should scrutinise providers' logs of complaints and allegations.

19.31 The Scottish Government should develop a national mechanism to gather, collate and analyse the patterns of complaints and allegations originating in residential child care units.

19.32 Glasgow City Council should review the capacity of its current Children's Rights Service to ensure it is able to provide the level of service needed

19.33 The Scottish Government should review the funding of children's advocacy services to ensure all looked after children have access to an independent, quality service.

Inspection

19.34 Inspections require to be followed up rigorously by the inspection bodies in order to effect change and improvement in services. Inspection agencies should check that internal and external managers of services are fully engaged in taking forward agreed actions.

19.35 As key concerns from inspection of Kerelaw by North Ayrshire Council were not passed to the Care Commission in 2002, the Scottish Government should ensure that, when changes in external scrutiny of social care services in Scotland take place in 2011, the new body has access to information gathered by previous inspections of the services in which it will have a locus.

Investigation and disciplinary processes

19.36 Where possible, investigations of allegations referred by providers of residential child care to the police should be carried out jointly by police and providers until the appropriate course of action – through the Courts or disciplinary procedures – can be determined.

19.37 Local authorities and other providers of residential child care should consider including independent support from outside the organisation for fact-finding in large and complex investigations of the kind required for Kerelaw.

19.38 Legal advice should be sought as early as possible in investigations where the possible outcome is the dismissal of employees. Such advice should reflect up to date expertise in Employment Law.

19.39 Providers of residential child care should review the application of their Codes of Discipline, and Disciplinary and Appeals Procedures and should keep up-to-date with best practice in HR and Employment Law.

Record keeping

19.40 While we do not wish to reiterate the recommendations of the Shaw report here, Glasgow City Council should reflect on these and ensure that records relating to looked after children are properly managed.

DWCL

19.41 To support improvements in the listing process from the new Protection of Vulnerable Groups legislation, employers and ex-employers should work quickly and efficiently to compile information and examine the robustness of the evidence before making a referral. Openness and co-operation between all parties, including the referred individual, are key.

19.42 There is no legal impediment to an employer investigating allegations about a former employee. As the ability to investigate thoroughly assumes that there is sufficient information, employers should ensure that they maintain accurate records of allegations, complaints, fact-findings and disciplinary disposals and any related material.

ANNEX A: TERMS OF REFERENCE

INDEPENDENT INQUIRY INTO ABUSE AT KERELAW RESIDENTIAL SCHOOL AND SECURE UNIT

Jointly commissioned by the Scottish Government and Glasgow City Council

Purpose

To secure comprehensive insight into the circumstances that led to the abuse that occurred at Kerelaw open and secure school from April 1996 until closure.

To examine Glasgow City Council's stewardship of Kerelaw School.

To consider the investigation by Glasgow City Council and post-school closure arrangements.

To make recommendations relevant to ensuring that the contributory factors which led to abuse at Kerelaw occurring and remaining unactioned for a protracted period cannot happen again.

To identify any other issues arising in the course of undertaking the Inquiry considered to be relevant to the safe care of young people in residential settings.

It is expected the inquiry will encompass consideration of:

- ◆ The school at the point of local government re-organisation in April 1996.
- ◆ The arrangements for children who were placed in and accepted by Kerelaw.
- ◆ The care planning and management of residents in the open school and the secure school.
- ◆ The effectiveness of arrangements for safeguarding residents, identifying concerns and responding to complaints.
- ◆ The recruitment, management and training of staff.
- ◆ The degree to which Kerelaw adopted best practice and implemented and learned lessons from other inquiries and reports, including, in particular, *Edinburgh's Children: The report of the Edinburgh Inquiry into abuse and protection of Children in Care* January 1999 and *The Fife Council Independent Inquiry* report of January 2002.
- ◆ Glasgow City Council's oversight of Kerelaw including management and accountability arrangements.
- ◆ The role of the bodies conducting inspection and registration functions in relation to Kerelaw.
- ◆ The arrangements for reviewing the complaints identified in 2004 and the subsequent closure of the school.
- ◆ The support offered to victims of abuse and former residents.
- ◆ The investigation undertaken by Glasgow City Council post-school closure.
- ◆ Subsequent steps taken by Glasgow City Council following the closure of the schools to ensure the safeguarding of children which it places in a residential care home or school.

Conduct of the Inquiry

The Inquiry will take place in private.

The Inquiry team may require access to confidential and personal information held by Glasgow City Council and Scottish Ministers (excluding information held by the Crown Office and Procurator Fiscal Service for the purposes of criminal investigations). In doing so, the Inquiry team will operate within the terms of a Code of Practice. The Code will comply fully with the Data Protection Act.

The report at the conclusion of the Inquiry will be anonymised as regards former members of staff and pupils at Kerelaw.

The published report will not contain reference to any information which could be considered prejudicial to any outstanding criminal case.

ANNEX B: “RULES OF ENGAGEMENT”

This Inquiry is not about individual cases. It is not about investigating specific allegations. Nor is it about identifying individuals or holding them personally to account.

It is about understanding how it was that abuse occurred at Kerelaw, the nature and extent of abuse, and how it went undetected. The Inquiry will consider among other things management structures and processes, recruitment procedures, cultural issues, and lines of accountability both inside Kerelaw and between Kerelaw and the Managing Authority. The Terms of Reference for the Inquiry can be found at: <http://www.scotland.gov.uk/Topics/People/kerelawinquiry/KerelawDocs>

The Inquiry will take into account the legal and regulatory framework within which Kerelaw operated during the period covered by the review, as well as the best practice prevailing at the time. It will consider the extent to which findings and recommendations from other relevant Inquiries were considered and, where appropriate, implemented. It will also consider the requirements and guidelines laid down by Glasgow City Council in relation to children in its care, and to Kerelaw in particular. It will also consider how the investigation of allegations and the follow-up to the investigation findings were handled within the Council.

The Inquiry will prepare a report for the Scottish Government and Glasgow City Council and will make recommendations. In doing so it will identify what lessons might be learned from the Kerelaw experience to ensure the future safety of children and young people in care.

All personal information given to the Inquiry relating to individuals will be confidential to the Inquiry and will be used anonymously to enable the terms of reference to be fulfilled and the report to be prepared.

No individuals will be named in the report, and all information will be handled safely and stored securely, in accordance with the attached data protection policy. Although commissioned by the Scottish Government and Glasgow City Council, the Inquiry is independent of both, and personal information provided to the Inquiry will not be passed to any third party. Anyone raising new allegations will be advised to contact the appropriate authorities. The Inquiry is not able to pursue individual complaints.

ANNEX C: SOURCES OF EVIDENCE

Former workers at Kerelaw

- senior managers
- care workers
- teachers
- other staff
- psychologists, psychiatrists, counsellors

Former residents of Kerelaw

Glasgow City Council

- Elected members
- Director level and above
- Senior social work and education staff
- External managers of Kerelaw
- Functional managers
 - Child protection
 - HR
 - Resources
 - Legal
- Investigation team
- Disciplinary chairs
- Placing workers focus group
- Residential managers focus group

Educational Institute of Scotland

Unison

Children's Rights Officers

Academics

HMIE

SWIA

The Care Commission

Association of Directors of Social Work

Barnardo's

Includem

Who Cares?

North Ayrshire Council

South Lanarkshire Council

Crown Office and Procurator Fiscal Service

The Scottish Government

Strathclyde Police

SIRCC

Families and/or partners of former staff and residents

ANNEX D: DISCIPLINE AND GRIEVANCE PROCEDURES - STATUTORY REQUIREMENTS AND GOOD PRACTICE

Statutory requirements

1. The present statutory requirements in relation to discipline and grievance have been in place since 1 October 2005. These require employers to have and to follow at least a basic written disciplinary procedure and, in the event that dismissal is expected, for a dialogue to take place between an employer and employee prior to that dismissal. An employer is also required to have a written grievance procedure and this and the disciplinary procedure must be fair and reasonable in their terms and implementation. Some changes to these statutory arrangements, in particular dispute resolution and the handling of unfair dismissal, will result from implementation of the Employment Act 2008, which is expected to come into force in 2010.

2. It is of vital importance that employers follow their procedures to the letter in matters of discipline and dismissal. In essence, the statutory requirement for standard disciplinary and dismissal procedures is for (1) a letter to issue from the employer to the employee stating the allegations against him or her and the basis of those allegations, and inviting the employee to a meeting; (2) a meeting to take place in which each party has the opportunity to state their case and the employee, who may be accompanied, to be notified of the decision; and (3) if the employee wishes to appeal, to hold an appeal meeting at which the employee has the right to be accompanied, and to inform him or her of the final decision. These standard requirements may be varied only where there has been gross misconduct and an investigation would make no difference. This is likely to be exceptional. If an employee is dismissed without the employer following the statutory procedure and makes a claim at an Employment Appeals Tribunal, the dismissal will be ruled unfair.

Best Practice

3 Employers should have written procedures that are clear, accessible and communicated to employees. Where an employer embarks on a disciplinary process, the employee concerned should be kept fully informed throughout. The initial letter should set out the allegations and the basis for these and the employee must be given an opportunity to respond.

4 Discipline procedures are frequently used to deal both with conduct (“won’t do”) and capability (“can’t do”) issues relating to individuals, although ACAS recommends a clear distinction be made between the handling of conduct and capability. It is acknowledged, however, that in many cases employers will find it difficult to make such a distinction between conduct and capability, and indeed there may be a mix of causes. If there is doubt, employers are advised to treat the matter as one of capability.

5 The aim of disciplinary procedures should be to achieve an improvement in conduct, taking into account the severity of the issue or incident in question. Most employers will therefore follow a cumulative approach in terms of disciplinary disposals, allowing an employee the opportunity to improve. This approach will generally provide for disposals of informal and formal oral warnings, first and final written warnings and dismissal. In cases of gross misconduct the employer may dismiss at the first instance, although the employee should know in advance that this is a potential outcome of the disciplinary process in his or

her case. More generally, employers should make their disciplinary procedures explicit in terms of the disciplinary disposal likely to arise as a result of particular disciplinary matters.

6. Once a disciplinary warning has expired, it is spent in terms of the disciplinary process, although it may be retained on file for management, but not disciplinary, purposes. Such information may be used, for example, in restructuring or redundancy exercises. If spent disciplinary records are retained for management purposes, this too should be made explicit in the procedures.

7. In all cases apart from exceptional incidents of gross misconduct that are subject to modified disciplinary procedures, there should always be a fact-finding investigation. A preliminary fact-finding should aim to clarify the matter in hand and crystallise the employees' position on that. A more detailed investigation may then be needed fully to gather the facts from a range of sources. This should lead to a recommendation on the need for a disciplinary hearing and an appropriate disciplinary disposal. It is good practice to arrange for the investigations and disciplinary hearing to be undertaken by different managers.

8. The employee under investigation should be kept informed of developments and the employers' investigations should be completed within 6 months of the initial letter to the employee. It is important during the proceedings that the employee understands whether a meeting is investigatory or disciplinary and the consequences for him or her, and that at all times he or she has the right to be accompanied.

ANNEX E: LIST OF ABBREVIATIONS

CHCP	Community Health and Care Partnership
COSLA	Convention of Scottish Local Authorities
CRO	Children's Rights Officer
Dip SW	Diploma in Social Work
DWCL	Disqualified from Working with Children List
EIS	The Educational Institute of Scotland
GTCS	General Teaching Council for Scotland
HMIE	Her Majesty's Inspectorate of Education
HNC	Higher National Certificate
HR	Human Resources
NRCCI	National Residential Child Care Initiative
SEHD	Scottish Executive Health Department
SIRCC	Scottish Institute for Residential Child Care
SMT	Senior Management Team
SSSC	Scottish Social Services Council
SVQ	Scottish Vocational Qualification
SWIA	Social Work Inspection Agency
SWSI	Social Work Services Inspectorate
TCI	Therapeutic Crisis Intervention



The Scottish
Government

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