

1 Tuesday, 12 February 2019

2 (10.00 am)

3 LADY SMITH: Good morning.

4 You'll all know that we began the closing
5 submissions yesterday and when I rose we were in the
6 course of hearing the submissions being given by Mr Gale
7 on behalf of FBGA, the Former Boys' and Girls'
8 Association from Quarriers.

9 Mr Gale, I think you probably have a short section
10 to finish, but it's obviously an important section, so
11 when you're ready, do feel free to start.

12 Closing submissions by MR GALE (continued)

13 MR GALE: Thank you, my Lady, good morning.

14 Before I do, there are two matters arising out of
15 yesterday that I could briefly mention. Yesterday,
16 Mr Peoples in his summary I think said that it was the
17 police who contacted David Whelan; in fact, it was
18 David Whelan who contacted the police.

19 LADY SMITH: Yes, I recall that.

20 MR GALE: I have just been asked to correct that.

21 I appreciate it was just a slip.

22 LADY SMITH: And there was evidence about events that took
23 place.

24 MR PEOPLES: I think I cut it rather short. The background
25 was in fact that Mrs QKR contacted David Whelan and

1 he then deliberated and, after that, he went to speak to
2 the police. I think that's the -- I fully accept --
3 I didn't realise when I said it that I perhaps missed
4 out that important chapter or part of the evidence.

5 LADY SMITH: Thank you for picking that up, Mr Gale.

6 MR GALE: The second point is we ended yesterday with
7 a discussion regarding what we say should be the
8 conclusion or finding that my Lady might make regarding
9 Mr Dunbar and the punishment books. Can I just ask
10 my Lady in that connection, when she comes to look at
11 this issue, to look at the two witness statements which
12 are footnoted at number 23 in our submission, both
13 Mr Dunbar and his wife Helen Dunbar. Helen Dunbar did
14 not give evidence, nor was her statement read in, but
15 it is a document that is available to the inquiry.

16 So with those two observations, my Lady, could
17 I return to the text? This is a section in which we
18 address the suggested findings of abuse that my Lady may
19 wish to make.

20 The evidence led in this case study has disclosed
21 a substantial body of consistent and compelling evidence
22 that abuse as defined has occurred in Quarriers Homes
23 within the period under consideration. Certain forms of
24 abuse have been highlighted in previous case studies and
25 it would appear that these have been replicated in

1 Quarriers.

2 We've indicated that those individuals convicted of
3 abuse provide an undeniable datum, but the scale of
4 abuse is, as we have already pointed out, disturbingly
5 high. We identify the following forms of abuse. And
6 I should point out, my Lady, that we don't suggest that
7 these are necessarily exhaustive, but we just highlight
8 these.

9 First of all, physical abuse and inappropriate
10 levels of punishment. Mary Drummond, Effie Climie and
11 Ruth Wallace were convicted of offences involving
12 physical abuse. I think also, my Lady, that
13 Alexander Wilson, among his convictions, there were
14 convictions for assault, not merely of sexual assault --
15 I should not have said not merely, but as well as sexual
16 assault. Exactly what those convictions for assault
17 were, I'm afraid we simply don't know, but it may well
18 be that he was also convicted of matters of physical
19 abuse and assault.

20 Many witnesses have spoken of acts of what may be
21 regarded as simply indiscriminate and gratuitous acts of
22 violence, albeit that the individual administering it
23 justified it as an act of punishment for some perceived
24 infraction of rules. House parents used implements such
25 as belts, tawses, sticks, canes, slippers, wooden

1 spoons, hairbrushes as implements of abuse. They also
2 used their hands and fists to deliver punches and slaps.
3 The victim could be of either sex, and age did not seem
4 to be a barrier to such abuse.

5 Almost all of these acts were designed to inflict
6 pain and regularly did. On occasions, children had
7 marks on their bodies, but often in areas that were not
8 immediately visible. The absence of punishment books
9 denies one the opportunity to consider whether acts of
10 punishment were commensurate with the level of
11 punishment provided for in standing order 7. The
12 evidence of witnesses would clearly suggest that the
13 episodes of indiscriminate violence would be most
14 unlikely to have been recorded.

15 Importantly, we say, my Lady, that the use of
16 physical violence was one of the aspects of abusive
17 practices that gave rise to what several witnesses
18 described as a sense of fear which pervaded individual
19 cottages. I appreciate there were other aspects as well
20 as just physical violence, but it was a significant
21 feature.

22 The second area we look at is bed-wetting, and this
23 is something, obviously, that has been dealt with by
24 Mr Peoples in some detail. There's not very much one
25 can add. Those who were bed-wetters were described as

1 having "an objectionable habit", and that the sympathy
2 lay not with the child but with the house mother who had
3 to deal with the consequences. That's obviously from
4 the standing orders. It is noted that such
5 a description is deemed relevant throughout the period.

6 Again, there is a compelling body of evidence that
7 the response to bed-wetting was entirely inappropriate.
8 On occasions, physical punishments were meted out, but
9 more frequently those who wet the bed were publicly
10 humiliated by having to wash their sheets or wear them
11 on their heads and carry them so that what had happened
12 would be apparent to all. It was particularly apparent
13 that those who knew that wetting the bed was
14 a possibility lived in dread of doing so.

15 Two witnesses spoke of still bearing the scars from
16 the pad and bell that was used. The second of those,
17 my Lady, is the witness William whose statement was read
18 in and there was an element of his statement, I think,
19 that Ms Rattray added to because he had contacted the
20 inquiry to say he still bore the scars of the pad and
21 bell. So that's the second of the witnesses from the
22 witnesses who gave direct evidence.

23 For those who lived in cottages where bed-wetters
24 were punished, the fact that in others the problem was
25 treated with sympathy and compassion must have increased

1 their feelings of isolation and probably of desperation.

2 Then I turn to force-feeding. This was
3 a distressing --

4 LADY SMITH: Just before you leave the matter of
5 bed-wetting, and in particular the use of the pad and
6 bell system, what are you actually saying about the use
7 of that system?

8 MR GALE: I think, my Lady, the fact that at least one
9 instance at the time was known to have caused injury
10 should have alerted those who were responsible for using
11 it to just that possibility, and that it should have
12 ceased at that stage.

13 LADY SMITH: Well, I'm not determining whether -- I can't
14 determine whether negligence occurred.

15 MR GALE: No.

16 LADY SMITH: The legislation prevents me doing that. I'm
17 just a little puzzled as to whether I'm being invited to
18 conclude that it was abusive to use it or whether it's
19 just part of a context that surrounds this treatment of
20 the bed-wetting problem.

21 MR GALE: I think we are asking my Lady to conclude that it
22 was abusive in that there was evidence of physical
23 injury occurring as a result of it, and to continue to
24 use that device in that knowledge was, we submit,
25 abusive.

1 LADY SMITH: Thank you.

2 MR GALE: My Lady, turning to force-feeding, this, as
3 I said, is a distressing -- distressing accounts have
4 been heard where children were physically held while
5 food was forced into their mouths.

6 My Lady will recall at least one witness indicating
7 that a house parent engaged the assistance of others,
8 I think the house aunties, to assist with that, where
9 those house aunties were perhaps reluctant participants
10 in what was being done, but that was part of the
11 evidence.

12 Some were forced to eat food that they simply could
13 not digest: the fish bones and gristle comes to mind.
14 On occasions they were forced to eat vomit that they had
15 thrown up on to their plates. These practices appear to
16 have been justified by staff who regarded a child's
17 inability to eat as indicative of ingratitude.

18 Some children devised mechanisms to avoid eating
19 food that they found inedible. They would pass it on
20 others who perhaps could stomach it. There are
21 certainly instances of pockets that were full of food
22 that they wanted to avoid.

23 Again, the fact that in certain cottages food was
24 good and such practices did not take place is a further
25 example of the lottery which a child's life was.

1 We turn now to separation from siblings and other
2 feelings of isolation. Again, this is going over
3 perhaps old ground. Cottages appeared to be separate,
4 self-contained units, and witnesses frequently spoke of
5 interaction with children in other cottages was
6 restricted to formal occasions such as attendance at
7 school or church.

8 Where house parents had reasons to protect
9 themselves from investigation as to their abusive
10 practices, they actively discouraged children from
11 communicating with others, sometimes through the threat
12 of violence.

13 There were instances, my Lady, where there was
14 interaction with other people from the outside world.
15 The children were presented in their Sunday best, but it
16 was made clear to them that they were not to communicate
17 anything, particularly anything negative about their
18 experience.

19 While separation of siblings of different ages and
20 sexes may have been explained by the provision of
21 separate sex cottages and age-appropriate companions,
22 what was of concern was the evidence that house parents
23 did not allow or encourage interaction between siblings.
24 There was evidence that some children were not aware of
25 the identities or even of the existence of their

1 siblings, even where those siblings were in another
2 cottage.

3 There was evidence that the parents of certain
4 children were denied reasonable contact with the
5 children by those in authority. It is particularly
6 reprehensible, we say, that in certain circumstances
7 those in authority perpetuated the misleading impression
8 that the parents were not known or were not interested
9 in their own children.

10 One particular example of this struck us, and this
11 again is William, the statement that was read in. He
12 believed that his mother had abandoned him and that
13 impression was perpetuated by those in charge. Indeed,
14 it's my understanding that he believed his mother was
15 dead.

16 Now, William is a gentleman I have spoken to on
17 a number of occasions in the room adjacent to here. It
18 was only when he gained access to his records that he
19 found out that that was not the case. Letters showed
20 that she had tried to contact him and it was
21 particularly gratifying to learn through talking to him
22 recently that he's now been able to see a photograph of
23 his mother, and in that his pleasure was obvious and
24 manifest.

25 There was also isolation in the shed at the rear of

1 some of the cottages, and that was used as a form of
2 punishment. On occasion, that was accentuated by
3 children being locked in cold and dark conditions.

4 My Lady, I turn to the matter of sexual abuse.
5 John Porteous, Samuel McBrearty, Alexander Wilson and
6 William Gilmore and Joseph Nicholson were convicted of
7 serious sexual offences. The evidence of the horror of
8 sexual abuse committed on vulnerable children was one of
9 the most distressing parts of this case study. Few who
10 sat as David Whelan or Elizabeth or Troy gave evidence
11 will easily forget that experience, but that is as
12 nothing compared to what those witnesses went through.

13 Again, my Lady, I wonder if I could just extemporise
14 slightly on that. David Whelan is obviously somebody
15 with whom I have conversed a great deal with over the
16 last two and a half years.

17 It was through listening to him giving his evidence
18 that I learned certain details that David had never felt
19 able to talk to me about in his conversations with me.
20 Again, that is a feature of many witnesses, that even
21 with somebody with whom they've established, in our
22 case, a professional relationship with, they find it
23 difficult to go into the detail of what actually
24 happened to them.

25 Elizabeth, my Lady will recall and I have already

1 mentioned, was the lady who, my Lady's encouragement
2 allowed her to come -- I think she said, "Come out of
3 her box", and express her evidence. She was a lady who
4 was perversely abused by the person she described as
5 "the dirty shoe man".

6 And finally Troy. He was the witness who gave
7 evidence of having been sexually abused. Again, it was
8 difficult to listen to, but my Lady will recall that he,
9 in giving his evidence, I think for the first time
10 explained the number of times that he had been abused
11 and he did that by holding up his hand and showing his
12 fingers. That again was a difficult part of the
13 evidence to listen to.

14 With that, my Lady, we turn to emotional abuse and
15 this covers, obviously, a lot of separate material. We
16 begin by saying that humiliation and ridicule are, we
17 say, particularly repellent forms of abuse and in this
18 case study there has been evidence of such abuse in
19 abundance. We have already referred to the public
20 humiliation of those who wet the bed and witnesses
21 frequently spoke to the general absence through to the
22 deliberate withholding of love and affection.

23 We appreciate that there required to be boundaries
24 so as to avoid inappropriate or disproportionate care so
25 as to avoid children being regarded as favourites, but

1 a level of human kindness towards children whose lives
2 may have been devoid of such consideration was, we say,
3 a basic entitlement.

4 Denigrating children directly and in the presence of
5 others for the perceived sins of their parents was
6 utterly disgraceful. My Lady will recall one witness
7 who indicated that clearly a house father, I think, knew
8 of him because of his own father's criminal past and
9 that was particularly repellent.

10 There were very clear examples of sectarian and
11 racial abuse, and the appalling racial and religious
12 abuse of Esmerelda was difficult to listen to and her
13 quiet dignity was humbling.

14 There was evidence that gifts intended for children
15 were either delivered but then removed or perhaps simply
16 not passed. The ways in which Christmas and children's
17 birthdays were celebrated unfortunately depended again
18 on the lottery of which cottage the child was resident
19 in.

20 My Lady, I have not mentioned the question of
21 instances where children were verbally abused, but
22 obviously that is something that occurred very
23 frequently. I have also not mentioned specifically the
24 requirement to call cottage parents "mummy", but
25 I alluded to it in the earlier evidence in relation to

1 Anne.

2 My Lady, concluding, a final word if I may on the
3 apology. The apology given by Ms Harper in this inquiry
4 has been delivered on behalf of the organisation after
5 she and the organisation's representatives have had the
6 benefit of hearing the detail of the abuse endured by
7 the survivors and the effects that abuse has had upon
8 them. Given what has happened in the past and
9 organisations such as FBGA and the survivors has and
10 have every entitlement to be sceptical and cynical.
11 However, we salute what Ms Harper has done, but it
12 remains a matter of great regret that earlier
13 opportunities were not taken to deliver this to all
14 survivors while still in life.

15 As is apparent from the evidence of both Mr Robinson
16 and Ms Harper, that failure to offer an unqualified and
17 sincere apology was delayed on instructions. As
18 Mr Robinson made clear, he was uncomfortable with the
19 position he was in, that he, the CEO of Quarriers at the
20 time, "firmly believed" the disclosures of abuse.
21 Notwithstanding that, the insurers took the position
22 that even in civil cases where abuse had been proved to
23 a higher standard in the criminal courts, the
24 organisation would be instructed to continue to deny
25 that abuse had ever taken place. That approach has

1 caused untold hurt and damage to survivors.

2 My Lady, before I conclude, obviously I've had the
3 opportunity to read the other submissions. Mr Scott's
4 submission in particular, so far as it contains general
5 observations and those relating specifically to
6 Quarriers, is a submission that I would respectfully
7 endorse.

8 Can I also add that Mr Scott makes a similar point
9 to that made in the final paragraph of my submission and
10 that's at page 6 of his submission. On its website,
11 IICSA indicates that it is conducting an inquiry into
12 the extent to which existing support services and
13 available legal processes effectively deliver reparation
14 to victims and survivors of child sexual abuse and
15 exploitation, obviously. They are not just restricted
16 to sexual abuse. That is in response to inter alia,
17 "multiple reports of obstructive insurance companies".
18 We would suggest, my Lady, that this inquiry should in
19 future case studies consider investigating that matter.

20 My Lady, with that --

21 LADY SMITH: Sorry, can I just be clear what it is you're
22 suggesting there by way of investigation? You mentioned
23 current support systems, but then also obstructive
24 insurers. It sounds as though there's a mismatch there.
25 Tell me a little bit more about that.

1 MR GALE: That's how IICSA described it on their website.

2 I accept there is something of a mismatch, but that's
3 how it's described.

4 LADY SMITH: Insurers would be involved with decisions as to
5 how to respond to litigation.

6 MR GALE: Yes.

7 LADY SMITH: I get that. The provision by public services
8 of appropriate support to survivors would be something
9 different.

10 MR GALE: I entirely appreciate that, but they are drawn
11 together in the inquiry that's currently taking place.

12 LADY SMITH: So you're really asking me to find out a little
13 bit more about that and decide whether it assists us to
14 understand what they're doing? It may be that what it's
15 getting at is covered by our terms of reference already,
16 but I can certainly check that.

17 MR GALE: It may be, my Lady. It is something we did raise
18 a little while ago with the inquiry team, so it is
19 something that we have highlighted.

20 LADY SMITH: Thank you.

21 MR GALE: With those submissions, I am grateful to my Lady
22 and unless there's anything I can assist my Lady further
23 with, those are our submissions.

24 LADY SMITH: Thank you very much for the time and trouble
25 you have taken over that, Mr Gale.

1 I am now going to turn to Mr Scott, who is here to
2 present the closing submission on behalf of INCAS. When
3 you are ready, Mr Scott, I am ready to hear you.

4 Closing submissions by MR SCOTT

5 MR SCOTT: Thank you, my Lady.

6 Before making submissions on behalf of INCAS on
7 specific findings in fact which her Ladyship may feel
8 able to make, I wish to start with some general
9 observations.

10 On 23 October of last year, the same day as opening
11 statements were heard in this case study, the Deputy
12 First Minister made a statement to the Scottish
13 Parliament in which he committed to establishing
14 a financial redress scheme for survivors of abuse in
15 care.

16 He also offered an unreserved apology on behalf of
17 the Scottish Government to all those who were abused as
18 children while in care. He was responding to
19 recommendations from the review group which had
20 consulted and engaged widely on the matter of redress.
21 That group recommended that a redress scheme be set up
22 by legislation before the end of this parliamentary
23 term, which is in March of 2021. It also recommended
24 that advance payments be made as soon as possible to
25 some survivors based on ill-health or age.

1 All of this is welcomed by INCAS and its members,
2 who will continue to press to ensure that everything
3 announced happens just as quickly as possible.

4 I note that there was an update from the Deputy
5 First Minister on 1 February confirming advance payments
6 to survivors who may not live long enough to apply to
7 the proposed statutory scheme, which scheme is to be the
8 subject of public consultation later this year.

9 He advised that the budget bill has now passed
10 stage 1 and has parliamentary agreement to pass at
11 stage 3, meaning that the £10 million set aside for the
12 advance payment scheme will be available from April of
13 this year.

14 He said that the budget will in effect be demand-led
15 and the provisional allocation of £10 million may be
16 higher or lower depending on the number of applications
17 received. Although outwith the terms of reference for
18 this inquiry, for survivors this is important parallel
19 work.

20 In relation to the Sisters of Nazareth case study,
21 INCAS notes that your Ladyship's findings are in hand
22 and will be published as soon as possible. The findings
23 are keenly awaited and INCAS again wishes to thank
24 your Ladyship for proceeding by way of interim findings
25 to allow some public recognition at as early a stage as

1 possible for many of those whose evidence has been heard
2 or read to date.

3 Turning then to this case study, looking at
4 Quarriers, Aberlour and Barnardo's. It offered its own
5 distinctive features, especially the fact of several
6 criminal convictions involving extremely serious sexual
7 and other abuse. The fact of those convictions has
8 informed the way we as a legal team for INCAS have
9 engaged with the inquiry. We took the view that there
10 was not the same scope as in the previous case studies
11 for any challenge or querying of the fact and extent of
12 abuse.

13 The main themes of my closing statement on behalf of
14 INCAS are reputation and responses. This case study,
15 my Lady, has offered an insight into the care offered on
16 behalf of the state by three secular organisations.
17 Although sadly, much of what we have heard, shocking
18 though it is, comes as no great surprise, it is
19 nonetheless worth commenting on the similarities of the
20 abuse suffered by children over many years at
21 establishments run by these three organisations and the
22 similarity to that suffered by children in homes run by
23 religious orders.

24 The similarities are such as to defy coincidence.
25 Even if there is little or no overlap in personnel as

1 between care provided by these organisations by
2 comparison to the religious orders. It does seem
3 remarkable enough to find evidence of such abuse as
4 we have already seen crossing establishments and
5 borders, but perhaps more understandable in the context
6 of religious orders, especially when we heard evidence
7 of a transfer of staff, for example from
8 Northern Ireland coming over to Scotland.

9 But here, we have heard evidence of the same or very
10 similar abuse crossing organisations and borders which
11 have no such apparent connection. Different children,
12 different abusers, different organisations, different
13 decades, but very similar abuse. I confess, my Lady,
14 it is not clear to me that any evidence-based
15 conclusions are possible on these remarkable features or
16 coincidences, certainly not at this stage. If any
17 conclusions are possible, it would no doubt be only at a
18 much more advanced stage of the work of the inquiry.

19 As I said in my opening statement in this case
20 study, there are considerations which have not featured
21 so far. That is particularly so because these
22 organisations continue to be trusted to provide care and
23 services for children and young people. It will be all
24 the more important therefore for the representatives to
25 demonstrate that they have changed from the time within

1 living memory when some of their predecessors in the
2 same organisations allowed abuse to happen, whether
3 negligently or knowingly, and even carried out abuse.
4 Hard-earned trust may have to be earned again.

5 In part, my opening statement anticipated the
6 reputational issues for each of these three
7 organisations of significant evidence of extensive abuse
8 even if involving staff and others now dead, certainly
9 no longer involved in the care of or services for
10 children which they provide.

11 INCAS welcome the active participation of each of
12 the three organisations in the case study and their
13 stated commitment to understand what happened and vouch
14 that everything possible will be done to avoid the
15 chance of it happening again.

16 Full and committed engagement by the three
17 organisations with the work of this inquiry in their
18 written evidence, in the case study, in attending the
19 hearings and after today in their response to the
20 eventual findings from this case study may offer some
21 reassurance that the grave wrongs of the past will not
22 be repeated.

23 Reputations are important. Another aspect of that
24 for survivors is the extent to which their reputations
25 have been called into question over the years. Active

1 participation by those whose organisations bear at least
2 some responsibility for the abuse perpetrated in their
3 establishments may offer additional insight for those
4 involved in the care of children, indeed for us all,
5 into the reputational issues for survivors, who are all
6 too used to being disbelieved, doubted and denigrated
7 for things which happened to them as children and for
8 which they bore no responsibility. This ties into the
9 myth of deserved abuse with troubled and challenging
10 behaviour treated not as communication to be understood
11 but as wickedness to be punished.

12 Before turning to the three organisations, it is
13 worth restating the need for all involved to avoid
14 answers and language which might be thought to deny,
15 minimise or excuse abuse. Phrases such as "excessive
16 corporal punishment", "overuse of corporal punishment",
17 or "improper use of corporal punishment" are often no
18 better than a euphemism for abuse. They should distract
19 no one from what happened but may suggest an attempt to
20 excuse that these were legitimate punishments taken
21 slightly too far rather than recognising them as the
22 abuse they were.

23 Phrases like that can help to perpetuate the myth of
24 deserved abuse. Survivors have attended these hearings
25 and other survivors away from this hearing are following

1 the work of the inquiry in various ways. All are
2 listening and none are fooled by exculpatory language
3 which serves rather to cause further damage.

4 Turning then to each of the organisations, I will
5 say only a little before making submissions on suggested
6 findings.

7 In relation to Quarriers, my Lady, in my opening
8 statement I said, as before in the next few months,
9 survivors are listening keenly to ensure that
10 acceptance, acknowledgement and apology are not
11 restricted to what has been proved beyond a reasonable
12 doubt in the criminal courts. We know that convictions
13 will stand as facts for the purposes of the inquiry and
14 not as opportunities for reheating rejected claims of
15 innocence and thereby causing further damage to
16 survivors.

17 Survivors were struck by the unqualified acceptance
18 on behalf of Quarriers of the fact and extent of abuse.
19 It was of particular note that their CEO stated that
20 even if an abused person was acquitted, that would not
21 mean that the abuse did not happen. That is precisely
22 the sort of approach I had in mind in my opening
23 statement, one that was not fenced by legal niceties or
24 grudging acceptance. Such an approach does help at
25 least some survivors and is greatly welcomed.

1 Turning to Aberlour briefly, this chapter provided
2 examples of the continuing need for great care when
3 putting in written evidence and also for framing
4 questions and it's really examples for us all --

5 LADY SMITH: And you're talking about requests for questions
6 going to counsel to the inquiry here, I think, aren't
7 you?

8 MR SCOTT: I am, my Lady.

9 On 17 December 2018, and it's on page 151 of the
10 transcript, the following question was asked -- and it
11 was stated that this was at the request of Aberlour:

12 "I have been asked to put the following description
13 of Michael to you by Aberlour, that he could be
14 described as an aggressive bully, who had a history of
15 physical assault, sexual assault, theft, truancy and
16 verbal and physical abuse. Does that fit with the
17 Michael you knew?"

18 In fact, my recollection is, my Lady, that the
19 witness didn't accept the premise of the question, so it
20 could go no further and that may in part explain why
21 things were left hanging as they were.

22 When asked about that question, at our request by
23 Mr Peoples in her subsequent evidence on Day 119, the
24 chief executive officer said that she welcomed the
25 opportunity to clarify the purpose of the intended

1 questioning. The intention was not, as she accepted may
2 have been the impression, to try to excuse or justify
3 abuse of the boy because of his behaviour, rather it was
4 to try to put into context a number of issues around his
5 progress and how he interacted with other children and
6 staff. Quite how the question came to be asked in the
7 way it was remains unclear or if it was the witness's
8 response that in effect left it the way it was. But it
9 emphasises, my Lady, I suggest, the need for continuing
10 care in all language used by us all in the presentation
11 of questions or other submissions to the inquiry.

12 Your Ladyship has been careful at all times to
13 ensure that all witnesses in the inquiry are treated
14 appropriately and sensitively and has taken great care
15 in the language she has used. This example is perhaps
16 a useful reminder to us all of the need for constant
17 care with our choice of words so far as those who are
18 listening here or elsewhere is concerned.

19 INCAS has always sought to recognise that the
20 history of child abuse being recorded in this inquiry is
21 not the whole story. And what is in the hearings is
22 clearly not the whole story either. There is abuse
23 which falls outwith the terms of reference, just as
24 there are also inspiring stories of excellent care from
25 committed individuals and of the triumph of humanity in

1 those who have experienced care.

2 Attempts to put an unjustified gloss on the past
3 will, however, be recognised and called out. The fact
4 of good care and the best of intentions on the part of
5 many, perhaps most, should not be seen as an opportunity
6 to try to spin good PR from sheer happenstance.

7 Some of the evidence from Aberlour suggested
8 a certain lack of care or perhaps overly favourable
9 interpretation in the preparation of statements and
10 evidence.

11 For example, what was claimed as a highly
12 significant example of children's voices being heard
13 turned out to be the result of the complete accident of
14 an overheard conversation between children. As was
15 pointed out at the time -- this was also on Day 119 --
16 by my Lady, and by Mr Peoples, there is quite a distance
17 between that claim and the supposed justification for
18 that claim.

19 To an extent the same might be said for Barnardo's
20 claim to be pioneers of training for residential staff.
21 While no doubt true or true as far as it goes or true to
22 some extent, to have to then concede that the training
23 was accurately described as patchy perhaps puts it in a
24 fuller context and it may be that by comparison to other
25 organisations, there was training where otherwise there

1 was none. But again, perhaps just an example of the
2 need to be careful.

3 There is very little to say about Barnardo's,
4 my Lady. It says on the website, on their website, in
5 the section "Who we are", that:

6 "We listen to them. We believe in them no matter
7 who they are, what they have done or what they have been
8 through."

9 That is consistent with what I have seen in the
10 closing statement for Barnardo's, which is now
11 available. It goes further, in fact, by saying that,
12 "We believe them", not just, "We believe in them", and
13 that is welcome.

14 That approach is a useful starting point for all of
15 those involved in the care of children, perhaps
16 especially where it is care for which the state is
17 ultimately responsible.

18 My Lady, the other theme for my closing statement is
19 responses. This brings us into some of the territory
20 well covered by Mr Gale. The fact of abuse in
21 establishments run by the three organisations is clear
22 and undisputed, even if the extent of it has been
23 sometimes, perhaps in the past, questioned.

24 For survivors, given that the clock cannot be turned
25 back, how they have been and continued to be affected

1 relates in large part to the response or the responses
2 they have received when speaking of the abuse they have
3 suffered. Of course, for some they were simply
4 prevented from doing so, whether because of an absence
5 of suitable procedures independent of abusers or because
6 of intimidation, whether explicit or merely implicit and
7 understood.

8 That some survivors have never shared their
9 experience until this inquiry can be explained at least
10 in part by knowledge of the responses to some of those
11 who tried to report their abuse. Often the first
12 response was that of the abuser or the abuser's
13 organisation. The reporting of abuse sometimes prompted
14 punishment and even victims being forced to apologise to
15 their abusers. Thereafter, and even recently, responses
16 have involved insurers and professional advisers, like
17 lawyers and, as I understand matters, in some cases,
18 even public relations experts. Here too survivors have
19 experienced further damaging behaviour.

20 Far from accepting the fact of abuse, even it seems
21 where that was the position of the Criminal Courts, and
22 even the insured organisation itself or at least a
23 senior office bearer in the organisation, it seems that
24 some insurers decided instead to maintain a position of
25 denial and, further, an attitude of accusation.

1 Claims rejected as unfounded. Contrary evidence
2 suppressed or simply not sought. Baseless allegations
3 of recovered memory or false memory syndrome. Hints of
4 purely financial motivation on the part of survivors.
5 In this respect, the evidence of chief executive officer
6 Philip Robinson from Quarriers, the former
7 chief executive officer, on Day 90, was extremely
8 troubling.

9 Even after the criminal conviction of Porteous, the
10 response of the Quarriers board, the insurers
11 Norwich Union, and the relevant lawyers was to deny
12 liability by denying that there had been abuse and then
13 contrive some sort of artificial defence involving
14 recovered memory and ensure that the apology offered was
15 wholly restricted and conditional, and I think your
16 Ladyship highlighted that at the time.

17 LADY SMITH: You should in passing, Mr Scott, perhaps
18 acknowledge that whilst Mr Robinson was the vehicle for
19 that information, as chief executive he was not a member
20 of that board. He was telling us about what other
21 people were doing and saying, not himself.

22 MR SCOTT: Indeed, and that's an important matter to be
23 recognised and indeed it was apparent that he felt
24 deeply uncomfortable about the approach taken and may
25 himself have made representations that a different

1 approach should have been taken.

2 LADY SMITH: Yes.

3 MR SCOTT: When the inquiry comes to consider the response
4 of government and others in due course, it is to be
5 hoped that such wholly inappropriate and damaging
6 responses will not be overlooked, contributing as they
7 have to further damage to survivors.

8 In passing, Mr Robinson's evidence on Day 90 raised
9 a question not yet, I think, fully answered about the
10 report by the Scottish Institute for Residential
11 Childcare, the forerunner to CELCIS. Mr Robinson seemed
12 to think that concerns around publicity affected what
13 was done or not done with that report, which had been
14 commissioned by Quarriers to provide a full independent
15 review of existing child protection arrangements.

16 I don't think we on the evidence fully understand
17 what happened with that report, but it may be that it
18 was another example of an inappropriate response and no
19 doubt further enquiry can be made in that regard.

20 Before turning to possible findings, there are two
21 final matters that I would wish to address, my Lady.
22 There is a general issue which persists relating to the
23 timing of disclosure to the INCAS legal team of evidence
24 relevant to each case study, especially where that
25 happens close to or even after the start of hearings.

1 The complications have been discussed before, primarily
2 in informal discussions between the inquiry team and my
3 instructing solicitor, Mr Collins, as well as
4 discussions with INCAS committee members. I do not want
5 to take up time on the issue today, important though
6 it is. Perhaps it would be more useful to say that
7 I will endeavour to assist in further discussions to see
8 if some of the technical issues can be addressed, which
9 might address continuing concerns.

10 We recognise the inquiry will no doubt continue to
11 receive evidence throughout its full term and during and
12 beyond specific case studies, posing challenges for the
13 inquiry. Those challenges for the inquiry team have
14 knock-on challenges for others who are seeking to work
15 with the inquiry. It may be that further discussions
16 could produce specific proposals to recognise the timing
17 of the loading of work related exclusively to disclosure
18 and any such proposals could then be submitted to
19 your Ladyship for consideration.

20 Another matter of some delicacy has also been raised
21 by INCAS members who have attended the hearings in this
22 case study. While survivors recognise that the hearing
23 room and certain other parts of this building are public
24 spaces which afford them no guarantees of separation
25 from those with different interests or involvement, it

1 appears that some survivors have been concerned about
2 certain behaviour and conversations by others with
3 a different interest. As the public phase of this case
4 study is about to be complete, this is more of a request
5 perhaps for greater consideration from those involved in
6 future hearings. As we have said before, it is hoped
7 that those involved in future case studies will study
8 what has happened in the case studies to date because
9 in that they may well benefit considerably from an
10 understanding of the work of the inquiry and what might
11 be considered an appropriate approach.

12 I will mention only briefly the reported behaviour
13 which caused the problems. It appears that some who
14 have attended have been unable to contain their views of
15 certain evidence with expressions of satisfaction when
16 it has been judged favourable and rather obvious
17 disapproval when it has not.

18 Insensitive remarks have also been heard which,
19 although no doubt not intended for survivors' ears,
20 display a lack of appropriate care and respect. This
21 whole process is undoubtedly challenging for everyone
22 involved in their own different ways, but that is
23 especially so, I suggest, for survivors who consider
24 that some of this behaviour and conversation has been at
25 times careless and insensitive, and it is to be hoped

1 that no such behaviour will be repeated and that greater
2 care will be taken by individuals when they are in and
3 around the building, not simply when they are being
4 recorded.

5 The last matter, my Lady, is in relation to
6 publication of evidence; I mention this only briefly.
7 In addition to some survivors -- and this has been
8 mentioned before -- the Scottish Human Rights Commission
9 and Rape Crisis have now added to the expression of
10 concerns about the publication of some of the detail of
11 sexual abuse and have suggested that redaction of
12 transcripts be considered again.

13 I appreciate that this is an extremely complicated
14 area and that the work of the inquiry and one of the
15 aims of the inquiry relates to making sure that everyone
16 understands what has happened, but I mention that
17 because it is something that continues to come up in
18 discussions with INCAS members.

19 So far as findings in fact are concerned then,
20 I turn now to the questions that your Ladyship should or
21 might find established on the evidence heard. In
22 approaching the making of findings in fact, a number of
23 factors may be relevant, are relevant. First and
24 foremost, perhaps is the fact of several criminal
25 convictions. While not determinative of all or

1 exhaustive of all relevant questions, these offer
2 a sound basis or support for certain findings.

3 Beyond evidence of convictions, the inquiry has
4 heard of patterns of abuse described by individuals of
5 different backgrounds and ages, resident in the various
6 establishments and entirely different decades and who
7 were and are strangers to each other.

8 As with previous case studies, what happened did not
9 involve only one or two abusers, it did not last for
10 just a short time, it involved many abusers and took
11 place over considerable decades.

12 The inquiry has continued to experience the
13 challenges of the passage the time, the destruction or
14 lack of records, and the fact that some witnesses were
15 very young children at the time of the abuse they are
16 telling us about. Despite this, there is clear evidence
17 of abuse, much of which is wholly uncontradicted.

18 My submissions are again in general terms and relate
19 to the body of evidence of practices which go beyond
20 individual witnesses. We have heard of similar or even
21 identical practices persisting over decades, despite the
22 inevitable changes of staff and children and it is this
23 evidence and these practices which form the basis of
24 most of my submissions.

25 Regrettably, many of these are similar to findings

1 suggested for previous case studies.

2 The first heading relates to sexual abuse. The
3 criminal convictions are of particular relevance here.
4 While more children were victims of other sorts of
5 physical, mental and emotional abuse, sexual abuse was
6 a significant and troubling feature of this cases study.
7 Boys and girls were subjected to sexual abuse, which
8 included indecent touching and significantly more
9 serious sexual activity, including rape.

10 On the question of training or the lack of training,
11 vetting and supervision, many staff had no
12 qualifications or experience for working with children.
13 Some, as in previous case studies, were very young with
14 no relevant practical experience.

15 This changed to an extent over time when greater
16 numbers of staff started to obtain relevant
17 qualifications and training was introduced at different
18 stages in different places. Even then it was not
19 a requirement. The training of residential staff was
20 patchy with the focus apparently on carers who were
21 fieldworkers rather than residential.

22 There was no consistency in the vetting of staff.
23 In the smaller cottage houses, there was no formal
24 supervision of staff, each cottage operating with
25 significant autonomy, allowing different and

1 inconsistent practices to develop in different parts of
2 the establishment so that we have a situation where
3 there were good cottages and bad cottages.

4 Awareness of abuse. Children made complaints of
5 abuse to staff members and others. Such children were
6 accused of lying, sometimes forced to apologise to their
7 abusers. Their complaints were commonly not pursued by
8 those who whom they were made, and indeed such
9 complaints often prompted punishment and further abuse
10 and acted as a disincentive to complaints being made.

11 In relation to control, discipline and punishment,
12 children of all ages were assaulted. This involved
13 beating of all sorts, with and without implements. It
14 was done, it seems, as a means of control, discipline
15 and punishment. It was used to punish bed-wetting, not
16 finishing meals and any other incident of perceived or
17 actual disobedience or misbehaviour.

18 In relation to verbal abuse, children were subjected
19 to horrific verbal abuse, some of which related to the
20 family or other circumstances which led to them being
21 received into care. As suggested by Mr Gale, this is
22 a particularly insidious form of abuse.

23 Bed-wetting humiliation perhaps being the most
24 common aspect of treatment. Again, children who wet the
25 bed being forced to stand beside the bed or to be

1 covered with their urine-soaked sheets in some way,
2 sometimes being beaten or given cold baths or showers.
3 This was done, it seems, as punishment and humiliation
4 for bed-wetting. Members of staff humiliated and
5 encouraged the humiliation of such children by others,
6 and there is the one instance referred to where members
7 of staff applied the pad and bell system, even where it
8 was shown to have caused injuries to the child.

9 Lack of human affection. This was a particularly
10 striking aspect of your Ladyship's findings in relation
11 to the first case study. As in previous case studies,
12 many children experienced no praise, no human warmth, no
13 love and no affection. There was, for many, no
14 atmosphere of nurture at all. Whether they did depended
15 to some extent on the attitude of individual members of
16 staff because there were some who did receive such human
17 affection.

18 So far, my Lady, as separation as families is
19 concerned, there was enforced, deliberate, unnecessary,
20 and therefore cruel, separation of siblings. Children
21 were allocated to different places according to age and
22 sex with no regard for family relationships and no
23 efforts made to maintain those relationships.

24 While the initial separations might have been
25 indicated for particular reasons, there was no reason to

1 prevent contact to continue.

2 We have heard of witnesses only discovering in adult
3 life that they had brothers or sisters and evidence of
4 the separation of siblings at Aberlour Orphanage,
5 Barnardo's house at Glasclune, South Oswald Road and
6 Balcary and various Quarriers cottages. It is spread
7 across so many houses and over such a wide range of
8 years that the evidence suggests this was or can now be
9 seen as an accepted institutional policy. Whether
10 a written policy or not; it worked in effect as
11 a policy.

12 I say nothing about forced migration, although there
13 was a little evidence heard about that. It is for
14 another case study at another time.

15 Records are always something worth mentioning
16 because the full extent of record-keeping throughout the
17 relevant period is contradictory and unclear. Many
18 relevant records no longer exist and the reasons for
19 that we don't know.

20 In relation to gifts we heard that in
21 Quarriers Homes gifts and presents were handed in which
22 were then removed from the children or destroyed.
23 Several cottages had this as a practice, which again
24 appears to be more than mere coincidence. It might be
25 seen as accepted institutional policy in practice, if

1 not in writing.

2 Washing. This is a heading that's not relevant to
3 Aberlour. Washing often involved numerous children
4 sharing the same bath, becoming increasingly cold and
5 filthy, obviously, with even passing child. There was
6 evidence of this at various Quarriers cottages, and at
7 the Barnardo's houses at Glasclune and Thorntoun, again
8 suggesting this was an established part of the regimes.

9 Finally, then in relation to food. The quality of
10 food varied with many witnesses accepting that their
11 food was good, but for some there was an issue where
12 they perhaps could not or did not wish to eat particular
13 food. Children were told to eat everything and
14 sometimes force-fed if they did not do so, and then
15 sometimes forced to eat their own regurgitated food or
16 to have their uneaten meals re-presented at the next
17 mealtime. We heard evidence of this practice in ten
18 Quarriers houses as well as in Aberlour Orphanage.

19 Those, my Lady, are what I submit could be
20 considered key findings, although again, as with
21 Mr Gale, not exhaustive.

22 Finally, my Lady, I wish to record my thanks to
23 Mr Peoples and Ms Rattray for continuing with the
24 excellent lines of communication previously established
25 which greatly assist in the smooth running of the

1 hearings and are of great assistance to us in
2 understanding how matters might progress. Mr Peoples
3 has also taken due account of our suggestions for
4 questions, for which I am grateful.

5 INCAS remain committed to the work of the inquiry,
6 my Lady. Its members and legal team will continue to do
7 whatever we can to assist in particular by way of
8 submissions and continuing communication.

9 It remains for me only to thank you, my Lady, for
10 the considerate and sensitive way in which you continue
11 to chair the inquiry. Very difficult, traumatic days
12 for survivors have been made a little easier because of
13 your obvious humanity as well as the other qualities
14 required of someone chairing such a demanding inquiry.

15 LADY SMITH: Thank you.

16 MR SCOTT: Thank you, my Lady.

17 LADY SMITH: Thank you very much, Mr Scott. I just want to
18 pick up on a couple of things you mentioned. Firstly,
19 the timing of disclosure and this is to do with release
20 of documentary evidence to these with leave to appear.

21 I'm pleased to note that you appreciate that the
22 continuing influx of documentary evidence does create
23 real challenges for the inquiry team and I would like to
24 take this opportunity to assure everyone that disclosure
25 does take place as soon as we can do so.

1 So far as the case study that's just drawing to
2 a close is concerned, Quarriers, Aberlour and
3 Barnardo's, I have been in close touch with the timing
4 of disclosures and I'm satisfied that they couldn't have
5 been made reasonably on any dates earlier than in fact
6 they took place. I know that people found that they
7 were sometimes under pressure because of that, but it
8 wasn't because of failures that could have been
9 rectified at this end.

10 Let me turn then to the mention that you made of the
11 inquiry's publication of details of sexual abuse in
12 transcripts that become available on the website. The
13 inquiry takes very seriously the full extent of its
14 duties to the public and it is important that everyone
15 understands that those duties include the following.

16 We are required to investigate the nature and extent
17 of abuse, and that means not just whether particular
18 types of abuse occurred, but what were the details of
19 that abuse.

20 We are required to create a national public record
21 and commentary on abuse, and that means there is an
22 obligation on us to put the details of the abuse that we
23 collect evidence about on record.

24 These are important aspects of that part of the
25 function of a public inquiry, which is about learning

1 lessons from exactly what went wrong in the past and
2 making recommendations about future protection and
3 prevention and, in the case of this inquiry, it
4 concerns, in addition, the fundamentally important
5 matter of the effective protection of vulnerable
6 children now and in the future.

7 The Inquiries Act 2005 requires me to secure that
8 members of staff are not only able to attend public
9 hearings but are also able to see a record of all the
10 evidence that is presented. We do that by publishing
11 the transcripts of the evidence. They reflect,
12 of course, what's already been put in the public domain
13 by the witnesses who have given oral evidence or have
14 provided statements which are read in at hearings.
15 Where redactions are made, they are done only insofar as
16 is necessary to protect the identities of those who are
17 entitled to anonymity.

18 This all means that we have not only a legitimate
19 interest in publishing the transcripts of evidence in
20 all the detail that we can do, we have a primary
21 statutory duty to do so. I hope it helps people to have
22 heard that and understand that it is not just a matter
23 of choice here and there; there are very important rules
24 that I have to follow when I decide what gets published.

25 Let me turn now to the next set of closing

1 submissions. That takes me, I think, to inviting the
2 Lord Advocate -- Ms Lawrie, you are here for the Lord
3 Advocate; is that correct?

4 Closing submissions by MS LAWRIE

5 MS LAWRIE: That's correct, my Lady.

6 Thank you, my Lady, for this opportunity to make
7 a closing submission to the inquiry on behalf of the
8 Lord Advocate. The focus of the present case study has
9 been on the residential childcare establishments run by
10 Quarriers, the Aberlour Child Care Trust and Barnardo's.

11 During this case study, the inquiry has heard
12 evidence about the abuse of children who were resident
13 to those establishments. The inquiry has also heard
14 that some of this abuse was both reported to and
15 therefore investigated and prosecuted by the Crown
16 Office and Procurator Fiscal Service, generally
17 shortened to the acronym COPFS. In particular, on
18 16 November last year, the inquiry heard evidence from
19 two COPFS officials, namely Kenneth Donnelly, procurator
20 fiscal, High Court, and Catherine White, Principal
21 Procurator Fiscal Depute.

22 Their evidence concerned the action taken by COPFS
23 in response to the police inquiry known as
24 Operation Orbona, which related to Quarrier's Village,
25 Bridge of Weir, Renfrewshire, and the outcomes of the

1 cases reported to COPFS.

2 In addition to this oral evidence, COPFS also
3 provided the inquiry with both a written report and
4 a supplementary report responding to questions posed by
5 the inquiry, again relating to the individuals reported
6 to COPFS for consideration of prosecution and the
7 outcomes of those reports.

8 A final report containing additional information
9 requested by the inquiry and some amendments was
10 provided to the inquiry on 22 January this year. This
11 evidence has informed the inquiry specifically about the
12 investigation and prosecution of cases relating to
13 Quarrier's Village at Bridge of Weir in the early 2000s.
14 It may also help to inform the inquiry more generally
15 about the legal background to and the practical
16 challenges involved in the investigation and prosecution
17 of the abuse of children in a residential care setting
18 and some of the ways in which the position has changed
19 over time.

20 Based on this evidence, I submit on behalf of the
21 Lord Advocate that the inquiry would be entitled to make
22 the following findings in respect of the investigation
23 and prosecution by the Crown.

24 First, as is detailed in the final report, that of
25 the 26 individuals reported to COPFS by the police, 16

1 were prosecuted and ten were convicted, of (inaudible)
2 one charge, although one of the ten prosecuted was
3 acquitted on appeal. I should also add that the figure
4 of ten includes Mr Brian McMenemy, who at the time of
5 his conviction was employed at a project run by
6 Quarriers, but none of the offences for which he was
7 convicted took place within an establishment run by
8 Quarriers. This information is provided at page 14 of
9 our final report.

10 The second finding is that, based in particular of
11 the evidence of Catherine White, that the Crown
12 investigation and prosecution of individuals reported to
13 COPFS as a result of the police inquiry was conducted in
14 a professional and thorough manner. Those involved took
15 account of the diverse needs of the survivors involved.

16 In conclusion, may I take this opportunity to
17 reiterate the Lord Advocate's continuing commitment to
18 supporting the work of the inquiry and to contributing
19 positively and constructively to its ongoing work.

20 Those are my submissions, my Lady.

21 LADY SMITH: Thank you, Miss Lawrie.

22 I would like now to turn if I may to
23 Police Scotland. Ms van der Westhuizen is here for the
24 police. When you're ready, I'm ready to hear you.
25

1 Closing submissions by MS van der WESTHUIZEN

2 MS VAN DER WESTHUIZEN: Thank you, my Lady.

3 My Lady, Police Scotland is grateful for the
4 opportunity to make this closing statement and continues
5 to be fully submitted to supporting the work of the
6 inquiry. During this phase of the inquiry we heard
7 testimonies from survivors who have been the subject of
8 abuse within Quarriers, Aberlour and Barnardo's
9 institutions. Police Scotland would like to acknowledge
10 the extent and impact of the abuse experienced by those
11 survivors and indeed all survivors of childhood abuse
12 across Scotland.

13 Police Scotland has provided and will continue to
14 provide the inquiry with information and evidence around
15 its own practices and policies and those of the eight
16 legacy police forces in relation to responding to
17 reports of child abuse in care establishments and how
18 this has evolved over time.

19 During this phase, Police Scotland assisted the
20 inquiry by providing a detailed report relating to
21 police investigations into the abuse of children within
22 establishments operated by Quarriers. A police witness
23 also attended and provided evidence to the inquiry
24 outlining the findings contained in that report.
25 Police Scotland would like to reassure the inquiry and

1 communities across Scotland that evidence heard will be
2 considered when refreshing current police policy and
3 practice in relation to the investigation of child abuse
4 and neglect. This will provide further opportunity to
5 enhance the skills and knowledge of its staff and
6 ultimately improve outcomes for survivors.

7 Police Scotland remains committed to investigating
8 all forms of child abuse. Such investigations can be
9 complex and challenging, but Police Scotland will
10 continue to investigate thoroughly all reported or
11 suspected child abuse in Scotland irrespective of when
12 that abuse occurred.

13 Re-investigations by Police Scotland's National
14 Child Abuse Investigation Unit into the non-recent abuse
15 of children within establishments operated by Quarriers,
16 Aberlour and Barnardo's continue alongside its joint
17 investigations with social work partners into recent
18 child abuse and neglect.

19 My Lady, Police Scotland will use any opportunities
20 presented during the course of this inquiry to enhance
21 and improve its understanding of child abuse and neglect
22 and to protect children at risk of harm.

23 Unless I can be of further assistance, that is the
24 closing statement on behalf of Police Scotland.

25 LADY SMITH: Thank you very much.

1 If I could now turn to the representation for
2 Scottish ministers, and I see Miss O'Neill you are here
3 this morning for the Scottish Ministers.

4 Closing submissions by MS O'NEILL

5 MS O'NEILL: Thank you, my Lady.

6 The inquiry and the other representatives here today
7 have the written submission from the Scottish Ministers.
8 I would formally adopt that but I don't intend to read
9 it out verbatim.

10 The first part of that written submission accords
11 with Scottish Ministers' continuing interest in all
12 aspects of this inquiry and its work and notes that the
13 ministers have been represented throughout the phase 3
14 hearings. That part of the submission also records the
15 role of the Scottish Government's Response Unit in
16 continuing to coordinate the provision of information by
17 Scottish Government to the inquiry.

18 And as with earlier phases of the inquiry, the
19 Response Unit has provided information to the inquiry
20 following the receipt of notices issued by the inquiry
21 under Section 21 of the 2005 Act.

22 My Lady, in relation to findings as to experiences
23 of abuse, although the ministers have been represented
24 throughout the phase 3 case studies, those representing
25 the ministers have not been actively involved in the

1 taking of evidence from witnesses who have given
2 evidence during the case study about their experiences
3 of abuse and, of course, are not here as representatives
4 of any of the applicants or the specific organisations
5 who are the subject of these case studies. As with
6 earlier phases of the inquiry, therefore, ministers did
7 not consider it would have been appropriate for them to
8 apply to the inquiry for permission to question those
9 witnesses and do not consider they had any basis on
10 which to test any evidence given by applicants during
11 the case study.

12 In those circumstances, my Lady, the Scottish
13 Ministers do not make detailed submissions on the
14 evidence heard by the inquiry or propose that the
15 inquiry should make specific findings in respect of the
16 accounts given by applicants as to events at
17 establishments operated by Quarriers, Aberlour or
18 Barnardo's.

19 My Lady, I make that point by reference to the
20 specific role of ministers in this inquiry and in
21 adopting that approach, the ministers do nevertheless
22 wish to acknowledge the very substantial evidence that
23 has been given by applicants of physical, sexual and
24 emotional abuse and neglect suffered by them as children
25 in care.

1 The next part of the submission concerns the
2 question of inspection. The ministers are conscious
3 that the nature and extent of inspections carried out at
4 Quarriers, Aberlour and Barnardo's has been the subject
5 of evidence during the phase 3 case studies. Individual
6 applicants gave evidence about the fact, extent and
7 impact of external inspections, as did former employees.

8 My Lady, there are footnoted references to just two
9 examples of this, but it's acknowledged that that was
10 referred to in the evidence of a number of witnesses.

11 In addition, some inspection material was put to
12 individual witnesses and the examples given are the
13 questions put to Ian Brodie on 15 November 2018
14 in relation to a Scottish Home Department inspection of
15 Quarriers carried out in 1965, which inspection report
16 appears not to have been shared in its entirety with
17 Quarriers at that time.

18 LADY SMITH: Can I take it from the way you have put that
19 that the Scottish Ministers are not able to dispute the
20 position as put by Quarriers, which is simply the report
21 was withheld from them?

22 MS O'NEILL: My Lady, this has been the subject of
23 correspondence with the inquiry team and the Response
24 Unit, the Scottish Government's Response Unit. It has
25 no more information than that which has been given to

1 the inquiry itself, but certainly from the records that
2 have been found within Scottish Government,
3 repositories, it appears that that report was not
4 provided at the time. What was provided was a summary
5 of recommendations at the time.

6 LADY SMITH: That was spoken to in evidence.

7 MS O'NEILL: Yes, my Lady, and I understand there would have
8 been historic reasons why that would have been thought
9 appropriate at the time and I don't intend to make
10 submissions about that, but certainly the
11 Scottish Ministers' records indicate that it was not
12 provided to Quarriers at the time.

13 LADY SMITH: Thank you.

14 MS O'NEILL: My Lady, separately, Professor Abrams' reports
15 on each organisation contained material relating to
16 inspection. In relation to such findings as
17 your Ladyship may make in relation to these case
18 studies, the ministers are conscious that the already
19 published findings concerning the Daughters of Charity
20 do not contained detailed findings in relation to
21 questions of inspection. It is, of course, absolutely
22 a matter for your Ladyship but the ministers
23 respectfully submit that it would not be appropriate to
24 make findings concerned specifically with inspections at
25 this stage given the further evidence that's anticipated

1 to be given in due course by Professor Levitt on
2 inspection generally and also given that
3 Professor Abrams' final report is to be disclosed at
4 a later date and the ministers may in due course make
5 observations on those reports.

6 LADY SMITH: Of course, as I think everyone will be aware,
7 inspection sits apart as a separate topic that touches
8 on every institution, every case study. It's not
9 peculiar to one particular institution, so it is being
10 looked at separately by the inquiry.

11 MS O'NEILL: Indeed so, my Lady, and for the ministers'
12 part, if there is an opportunity to make comprehensive
13 submissions on the issue of inspection, that would be
14 welcomed.

15 LADY SMITH: I can see that and I can see there's logic in,
16 at the very least, waiting until we have heard the
17 totality of Professor Levitt's evidence. He has given
18 very good helpful evidence already, but chronologically
19 it's not yet complete, which it will be in the not too
20 distant future. But there's time for that later on.

21 MS O'NEILL: My Lady, the last part of the written
22 submission deals with the issue of recommendations for
23 reform and improvement.

24 The Scottish Ministers listened carefully to all the
25 evidence given during this case study, but particularly

1 to the evidence given during the panel session on
2 30 January this year involving SallyAnn Kelly of
3 Aberlour, Charles Coggrave of Quarriers and David Beard
4 of Barnardo's. Their discussion was wide-ranging and
5 rich in content, touching on topics that included: the
6 Health and Care Staffing (Scotland) Bill currently
7 before the Scottish Parliament; the work of public
8 bodies such as the Care Inspectorate and
9 Disclosure Scotland; the regime for registration and
10 regulation of care workers by the Scottish Social
11 Services Council; recruitment and retention of staff;
12 procurement of care services by the public sector
13 including local authorities; advocacy and mentoring
14 services; whistle-blowing; protocols concerning children
15 who go missing from a care setting; the independent Care
16 Review; and the National Child Protection Leadership
17 group.

18 That evidence will no doubt contribute to the
19 fulfilment of the inquiry's sixth and seventh terms of
20 reference, which, put shortly, are to consider whether
21 issues of abuse have been addressed to date by changes
22 to practice, policy or legislation or whether further
23 changes to practice, policy or legislation are needed.

24 Again, it is a matter entirely for the chair, but
25 Scottish Ministers anticipate that formal findings and

1 recommendations in respect of these aspects of the terms
2 of reference will not be made in the context of
3 individual case studies and are likely to be dealt with
4 at a much later stage in the inquiry's work.

5 LADY SMITH: I can say the Scottish Ministers anticipate
6 correctly in that regard.

7 MS O'NEILL: And in that respect, my Lady, all that the
8 ministers would wish to do at this stage is record their
9 willingness and desire to provide the inquiry in due
10 course with evidence and submissions on all of the
11 matters mentioned previously and of course the content
12 of that evidence and any submissions will depend to
13 a degree on the timing and on events between now and the
14 time when the inquiry finally reports.

15 I am conscious that there was discussion of the
16 Health and Care Staffing (Scotland) Bill. That bill has
17 no now completed stage 2 in its passage through the
18 Scottish Parliament and has been the subject of
19 amendment by the Health and Sport Committee. Should the
20 bill be passed and receive royal assent it is expected
21 to provide for the issuing of ministerial guidance on
22 staffing and the development of staffing methods,
23 including the use of what are called staffing level
24 tools in the NHS and in care services. The bill does
25 not have a specific focus on childcare services but the

1 inquiry may wish to hear evidence about the operation of
2 the bill in practice if it is passed and brought into
3 force before the end of the inquiry's work.

4 The Scottish Ministers are more directly responsible
5 for some of the other matters about which evidence was
6 given, for example Disclosure Scotland is an executive
7 agency of the Scottish Government and has no legal
8 personality separate from that of the government, and
9 the National Child Protection Leadership Group is
10 a non-statutory group convened by the
11 Scottish Ministers, whose aim is to identify means by
12 which more effective consistent protection and support
13 for children and families can be delivered and to reduce
14 duplication of effort. SallyAnn Kelly gave evidence
15 that she is a member of that group, my Lady. The group
16 also provides scrutiny and advice to Scottish Government
17 on proposed policy changes.

18 While not directly responsible for independent
19 statutory agencies such as the Care Inspectorate and the
20 Social Services Council, the ministers obviously have
21 a clear interest in their work and a key role in
22 ensuring that the legislative framework within which
23 they operate is fit for purpose. The government
24 Response Unit would welcome the opportunity to discuss
25 with the inquiry team how it might best contribute to

1 the inquiry's work in these areas.

2 LADY SMITH: Thank you very much.

3 I think we'll take the morning break at this stage,
4 so I will rise for a quarter of an hour or so just now
5 and then sit again for the remainder of the submissions.

6 (11.22 am)

7 (A short break)

8 (11.44 am)

9 LADY SMITH: I'm now going to turn to the closing
10 submissions that are to be presented on behalf of
11 Quarriers. So Ms Dowdalls, when you're ready, I'm ready
12 to hear from you.

13 Closing submissions by MS DOWDALLS

14 MS DOWDALLS: Thank you, my Lady.

15 Quarriers has already provided a rather lengthy and
16 detailed written closing submission to the inquiry.
17 I don't intend, my Lady, to read that submission in its
18 entirety. If I may, however, what I intend to do is to
19 summarise the content of that submission, which is
20 of course adopted by me in any event on behalf of
21 Quarriers. I also intend to take the opportunity to
22 respond briefly to some of the issues that were raised
23 this morning and yesterday in the submissions of others.

24 Before I do, however, my Lady, may I express on
25 behalf of Quarriers sincere thanks to yourself, my Lady,

1 and the inquiry team for the approach that has been
2 taken to this case study. Your Ladyship's sensitive and
3 respectful approach to survivors and former employees
4 who have come and given evidence has allowed the
5 witnesses to speak freely about difficult and often
6 upsetting issues. The willingness of the inquiry team
7 to incorporate questions put by Quarriers into the
8 examination of witnesses has assisted the flow of the
9 evidence and minimised distress to those witnesses.

10 The Witness Support team has facilitated
11 communication between Quarriers management and the
12 witnesses following the witnesses having given their
13 evidence and Quarriers management is particularly
14 grateful to them for that.

15 I am grateful also to yourself, my Lady, for
16 allowing me to raise issues with some of the witnesses
17 when the need arose at the conclusion of their evidence.

18 The current management of Quarriers apologised to
19 those who suffered abuse while in the care of the
20 organisation during phase 1 of this inquiry in
21 June 2017, and again apologised in opening statements
22 made at the outset of this case study before any
23 evidence had been heard.

24 More recently, the CEO, Mrs Harper, apologised
25 personally and on behalf of the organisation to any

1 person who had been abused while in Quarriers' care. In
2 making these closing submissions, Quarriers again
3 reiterates that acknowledge and that apology.

4 As an organisation, Quarriers has acknowledged that
5 there was widespread abuse of children at
6 Quarrier's Village and that abuse occurred at other
7 establishments that were run by the organisation. Seven
8 former employees and the son of former house parents
9 have been convicted of abusing children in the care of
10 Quarriers during the 1950s to the 1980s. Others have
11 been tried and acquitted or have successfully appealed
12 conviction. Quarriers acknowledge that the absence of
13 a conviction does not mean that no abuse occurred.

14 The accounts given to the inquiry, information from
15 the criminal cases, disclosures made to Quarriers'
16 safeguarding and aftercare department, evidence through
17 the Time To Be Heard pilot scheme and other sources
18 provide a compelling body of evidence that widespread
19 abuse occurred at Quarrier's Village.

20 Certain themes have emerged during the evidence.
21 Some of these themes relate to what can only be
22 described as abuse. Others relate to practices and
23 responses to behaviour including responses that were
24 inappropriate and amount to abuse. Some witnesses
25 recounted positive experiences of their time in

1 Quarriers' care and it is apparent from the evidence
2 that experiences were mixed.

3 That any child suffered abuse in Quarriers' care is,
4 however, unacceptable. It's important for this inquiry
5 to highlight the abuses suffered by children and the
6 efforts that have been made since and continue to be
7 made to protect vulnerable children from abuse in the
8 future.

9 I will discuss now, if I may, the themes that I have
10 just mentioned by reference to the practices and
11 circumstances that were described by the witnesses in
12 their evidence.

13 The first of those themes is physical abuse. There
14 is ample evidence that children were physically abused
15 at Quarrier's Village. There is documentary evidence
16 that physical abuse in the form of disproportionate
17 physical punishment and assaults took place as long ago
18 as 1937.

19 Acceptable standards of corporal punishment have
20 evolved over the years since the 1930s. It was once
21 unremarkable for corporal punishment to be used in
22 schools and in the home. However, excessive or
23 disproportionate physical chastisement of children has
24 never been acceptable. It's clear that there are
25 instances of house parents and others using physical

1 chastisement which went well beyond what was considered
2 acceptable at the time.

3 Some of the physical abuse perpetrated by
4 house parents can only be described as cruel and
5 sadistic. There was evidence of children being
6 strapped, including from some who described being lined
7 up and strapped using a tawse on the return from days
8 off of certain house parents. Some survivors described
9 being hit, as they put it, often and hard and being
10 struck with sticks.

11 There was evidence of wet or soiled underwear and
12 bed linen being rubbed in children's faces, children
13 being forced to sit on a stool for hours, holding their
14 hands above their heads for lengthy periods or holding
15 out piles of books. One witness described seeing boys
16 standing for long periods facing a wall. Accounts were
17 given of physical punishment for running away and also
18 for bed-wetting.

19 The tawses were ordered to be withdrawn from the
20 cottages when Roy Holman was appointed superintendent in
21 1964. However, in a 1965 report, which I will discuss
22 later, it was indicated that not all cottages had by
23 that time returned them to the head office.

24 The use of corporal punishment was banned by
25 Quarriers' management in the mid-1970s. There's

1 evidence, however, that in 1977, Dr Minto, who was then
2 the general director discussed the possibility of the
3 reintroduction of what was described as a mild form of
4 corporal punishment for young children and he discussed
5 that with the Social Work Services Group. He was
6 discouraged from the reintroduction of that policy.

7 It's not clear what the policy at that time actually
8 was. However, according to the evidence of Bill Dunbar
9 on Day 89, corporal punishment was banned in the 1980s
10 in Quarrier's Village.

11 LADY SMITH: But that timing, of course, would fit with the
12 change in the law after the cases had gone to the
13 European Court of Human Rights in Strasbourg.

14 MS DOWDALLS: Indeed, my Lady.

15 Some witnesses described alternative punishments
16 such as being sent to your room, which one described as
17 a "calmer" approach than he had experienced in
18 a different cottage. That was the evidence on Day 82.

19 The next theme that I will mention only briefly is
20 the theme of sexual abuse. Four former employees of
21 Quarriers were convicted of sexual offences. One child
22 of former house parents was also convicted of sexual
23 offences which he committed when he was under 16 and
24 living with his parents at Overbridge. Others have been
25 accused of sexual abuse. Quarriers makes no comment

1 in relation to those accusations, save to observe once
2 again that the absence of a conviction does not
3 necessarily denote the absence of a crime.

4 The next theme I will discuss briefly, my Lady, is
5 bed-wetting. There was a large body of evidence from
6 survivors and former employees regarding the issue of
7 bed-wetting and how children who wet the bed were
8 treated. Although some children reported being treated
9 with kindness and consideration, there can be no doubt
10 that many were humiliated and punished for wetting the
11 bed.

12 Punishments including being made to take wet sheets
13 to the laundry, albeit that was a practice that ceased
14 when it came to the attention of Mr Munro in 1960
15 according to the evidence of Mr Dunbar. Some children
16 were placed in cold baths and there was some suggestion
17 in the evidence that that may have been intended to get
18 rid of the smell of urine, but it was certainly regarded
19 by those who experienced it and gave evidence about it
20 as a punishment. Some former residents reported being
21 shouted at, humiliated and physically struck, responses
22 which were plainly inappropriate and reprehensible.

23 There was evidence of the use of the pad and bell
24 already discussed in submissions heard earlier today and
25 yesterday. That was a mechanism that was used as

1 a means to prevent or cure enuresis. Although
2 criticised by former residents, two of whom describe
3 being injured as a result of its use -- and I pause to
4 note here, my Lady, that in the lengthier written
5 submission reference had been made to one witness. On a
6 review of the evidence following the submissions by
7 Mr Gale yesterday, I confirm that the number is indeed
8 two witnesses: Matt and William.

9 The use of the pad and bell was a medically
10 recognised and prescribed response to chronic
11 bed-wetting. It's understood, and I am told, that
12 enuresis alarms more generally remain a medically
13 recognised and prescribed response to chronic
14 bed-wetting.

15 There has been reference made in submissions,
16 my Lady, to injury caused by the use of the pad and bell
17 and a question was raised whether its very use ought to
18 be characterised as abuse. As I understood the
19 evidence, my Lady, there was very limited medical
20 evidence that the cause of the injury to Matt may have
21 been the use of the pad and bell, and that medical
22 evidence, such as it was, indicated that Matt would be
23 taken off, I think the expression was, the pad and bell
24 as a consequence of that.

25 In my submission, my Lady, it is difficult to

1 describe its use, standing that it was a medically
2 recognised treatment, if I can put it so, for
3 bed-wetting as abuse. Perhaps the abuse lies more
4 in the effect emotionally upon the children of being
5 singled out and the use of the pad and bell as a means
6 by which to humiliate children from time to time.

7 Moving on, my Lady, several former residents
8 described incidences of force-feeding at Quarriers,
9 including being physically held and force-fed food into
10 which they had vomited. Some also described being
11 deprived of food as a punishment. Those practices were
12 plainly unacceptable.

13 Former residents also gave evidence about being
14 isolated, some described having been put in a cupboard
15 or having been put into the shed annexed to the house as
16 a punishment, some of those for long periods. The
17 practice of sending a child to the shed for a lengthy
18 period or in inadequate clothing was plainly
19 unacceptable.

20 Some former residents described being given
21 responsibility for chores. The expectation that
22 children would help around the cottage and take
23 responsibility in an age-appropriate way for some
24 household tasks is, of course, not unreasonable --

25 LADY SMITH: I don't think anyone is suggesting the very

1 fact of engaging children in carrying out chores is
2 abusive. Indeed, you need to teach children how to play
3 their part in looking after a household. It's when it
4 becomes too much for the child and taking account of
5 their age and ability that it can be used abusively.

6 MS DOWDALLS: Indeed, my Lady, and it's acknowledged by
7 Quarriers that some children were expected or required
8 to do far more than was reasonable given their age and
9 stage at the time.

10 LADY SMITH: I think the context of some of that was very
11 limited or in some cottages the absence of domestic
12 assistants for the house mother; would that be right,
13 according to some of the evidence?

14 MS DOWDALLS: The evidence suggested, my Lady, that as
15 domestic assistance in the cottages improved and were
16 increased, there was a reduction in the expectation that
17 children would be expected to carry out tasks, and
18 certainly I think the evidence of Carol McBay, a former
19 house parent, was that when she came in as
20 a house parent, she recognised that what the children
21 expected to do was far beyond what she expected them to
22 have to do and she changed the regime at that time. So
23 there certainly appears to have been a change in
24 attitude and approach as time progressed.

25 I will discuss, if I may, at some length the issue

1 of emotional abuse. That expression may be taken to
2 include a number of practices or behaviours, not all of
3 which were intended to hurt or distress children.

4 However, well-intentioned some of the practices might
5 have been, they clearly had a significant impact on the
6 young people towards whom they were directed, and for
7 that Quarriers apologises.

8 Examples of emotional abuse, about which there has
9 been evidence during this inquiry, include such things
10 as calling the house parents mummy and daddy. The
11 practice of encouraging children to call house parents
12 mummy and daddy was described by many witnesses. Some
13 said that they were compelled against their will to do
14 so and some gave evidence that they were happy to do so.
15 One witness said it just happened and his account of his
16 time in Quarriers was a positive one. He said he was
17 made to feel important and part of the family and he
18 called his house parents mum and dad because, as he put
19 it, "That's what they were to me". For others, the
20 practice of calling house parents mummy and daddy or mum
21 and dad was plainly distressing, especially as most of
22 them had parents of their own.

23 The next issue is the separation of siblings and
24 restriction of family visits. Some former residents
25 spoke of being separated from their siblings. Others

1 spoke of having been placed throughout most or all of
2 their time at Quarriers with their siblings. Some
3 witnesses suggested that the practice of separating
4 siblings may have been due to the availability of
5 accommodation, the sex of the child, or the need for
6 a very young child to be placed in the nursery. The
7 practice of separating siblings, it is submitted,
8 lessened over the years.

9 Bill Dunbar spoke in his evidence about changes in
10 society and described:

11 "A gradual process of changing from individual boys
12 and girls' cottages to having mixed cottages."

13 One witness described efforts being made to place
14 her and her siblings in the same cottage when they were
15 resident at Quarrier's Village during the late 1950s.

16 I was reminded yesterday that the standing orders
17 from 1930 make some provision for brothers visiting
18 sisters and that the 1965 report that I have already
19 mentioned briefly and will discuss further later notes
20 that by that time there was a positive policy of keeping
21 children of one family together in a cottage where
22 possible.

23 The distress, however, caused to children by
24 separation from their siblings is acknowledged by
25 Quarriers and is very much regretted.

1 On restrictions of visits from family members, some
2 witnesses described positive visits from family members.
3 Those were positive events in their evidence. There was
4 evidence in some of the records of regular family visits
5 and there were also records showing that some children
6 were rarely visited by family members or that planned
7 visits did not take place.

8 There's evidence in children's records of Quarriers
9 encouraging parents to visit children, both when they
10 hadn't visited for some time and when they had failed to
11 attend for planned visits. There is also evidence of
12 families being asked not to visit or to restrict the
13 extent of their visits because the children found them
14 unsettling.

15 Many survivors described lack of affection from
16 their house parents and described not being hugged or
17 cuddled, being told they were useless or worthless and
18 that they weren't wanted. Others described being cared
19 for and given attention and affection by house parents
20 and other staff members. The lack of uniformity of
21 standards of care and of approaches of house parents
22 resulting in very different experiences for children in
23 Quarriers' care is acknowledged and is regretted.

24 On the matter of celebrations, including Christmas
25 and birthday celebrations, these were discussed during

1 the evidence of many former residents and staff. Most
2 recalled Christmas celebrations including a special
3 meal, a church service and gifts. Recollections of
4 birthday celebrations were more mixed, with some former
5 residents describing cakes, cards and gifts to mark
6 birthdays, and others saying that birthdays weren't
7 marked at all. There was also evidence that children
8 weren't allowed to keep gifts that had been given to
9 them. The absence of celebration of events such as
10 birthdays and Christmas would certainly have been
11 upsetting for children and, again, the apparent lack of
12 consistency and uniformity of care and attention is
13 regrettable. It was suggested earlier that the removal
14 from children of gifts might have been some policy of
15 Quarriers. The lack of consistency of approach of
16 house parents in that respect would rather tend to
17 suggest that that was certainly not a policy but rather
18 a practice engaged in by some house parents. We have
19 heard and this inquiry has heard evidence about the
20 autonomous nature of the house parents' role and
21 responsibilities.

22 Moving on, my Lady, there was evidence that
23 especially in the early years, some children felt that
24 they were depersonalised. Specifically, children had
25 little choice as to the clothes that they would wear and

1 some felt that the effect of having to wear clothes that
2 were shared or the same clothes as everyone else at
3 Quarriers depersonalised them. There was also, my Lady,
4 I recall, evidence from a house parent who recognised on
5 taking up her role that that was a practice that had
6 existed under the regime of the previous house parent
7 was one that she was very keen to move on from and to
8 discontinue.

9 The wearing of standard issue clothes was identified
10 in the evidence as something that set the children apart
11 from other children, set them apart as being Quarriers
12 children, particularly at school. That somewhat
13 institutional approach was not so apparent during the
14 later years at Quarrier's Village, I would submit.

15 The issue of religious and racial bigotry has also
16 been raised. Quarriers Homes was founded on the basis
17 of a Christian, mainly Protestant, ethos and there has
18 been evidence that recruitment was largely based on
19 assessing the Christian character of applicants. Thus,
20 most or possibly all of the house parents were from
21 a Christian Protestant background.

22 In the early years, many of the children were
23 referred by the local minister. It is unsurprising
24 perhaps, therefore, that most of the children looked
25 after at Quarriers were from white Scottish Protestant

1 families. The inquiry has heard little evidence of
2 religious or racial diversity among the children and
3 none about religious and racial diversity among
4 house parents and other employees.

5 There was evidence that one house parent was
6 critical of management for placing a Catholic child in
7 her care, although no evidence that the child was
8 neglected or abused as a result. One former resident
9 gave evidence that during her time in Quarrier's Village
10 in the early 1960s, and I refer here to Esmerelda, as
11 well as how there were other black children in the home,
12 she described racist language being directed towards her
13 and a lack of attention to the specific needs of black
14 children, such as in caring appropriately for their hair
15 and skin, and that is deeply regretted by Quarriers.

16 There was evidence also in relation to peer abuse
17 and there can be no doubt that there was peer abuse in
18 some of the cottages at Quarrier's Village and at
19 Overbridge. As I mentioned earlier, the son of the
20 house parents at Overbridge was convicted of sexual
21 offences committed while he was under the age of 16 and
22 while he was living with his parents at Overbridge.

23 There was evidence of house parents at
24 Quarrier's Village turning a blind eye on physical and
25 also sometimes sexual abuse of other children by

1 residents, by peers. That peer abuse went unchecked is
2 deeply regrettable.

3 The records have revealed some evidence and concerns
4 about safeguarding young people at Southannan and
5 Seafield from the risk of peer abuse. In more recent
6 years, evidence has emerged of peer abuse at Seafield.
7 However, the robust procedures in place at that time
8 meant that these incidents were dealt with appropriately
9 and the police and other agencies were informed.

10 On the matter of absconding, the issue of responses
11 to children absconding arose in the evidence of some
12 former residents. Absconding and the reasons for it do
13 not appear to be investigated thoroughly, if at all, by
14 staff or managers at Quarriers. One former resident
15 described his house parent being relieved to see him
16 back safely -- I think that was the young man to went to
17 Glasgow for Hogmanay -- while others spoke of being
18 punished for having left.

19 I will say a little now about aftercare services and
20 approaches to aftercare.

21 There were some positives emerging from the evidence
22 relating to services for young people preparing to leave
23 Quarriers and live independently. Quarriers had
24 established a hostel at Quarrier's Village in 1971 where
25 young people could live and begin to develop independent

1 living skills, albeit with supervision and support.
2 Bill Dunbar gave evidence that he was responsible for
3 supervising aftercare services and that he helped young
4 men by placing them in jobs. His evidence was that
5 there was supervision for about a year to 18 months
6 after leaving Quarriers.

7 From the early days of Quarriers Homes there was
8 training for work on ships and in domestic service.
9 Later Quarriers assisted young people with finding work
10 placements and help with job applications. There was
11 evidence throughout the decades of some follow-up
12 communications between Quarriers management and former
13 residents. Many former residents, however, gave
14 evidence that the support they received on leaving
15 Quarriers was inadequate and that they were entirely
16 unprepared for life outside Quarrier's Village.

17 Overall, the experiences of former residents as to
18 support and preparation for leaving appear to have been
19 mixed, but the records do tend to demonstrate that
20 greater attention was paid to the need for preparation
21 for leaving and the need for ongoing support from the
22 1970s onwards.

23 I'll move on, if I may, my Lady, to discuss issues
24 under the broad heading of systemic failures. Quarriers
25 has sought to explore during this inquiry what

1 deficiencies in its historic systems and practices
2 allowed abuse of the vulnerable children in the care of
3 the organisation to occur. These deficiencies
4 contributed to an environment where widespread abuse
5 could occur and go undetected or unchecked.

6 Children didn't often complain. There was evidence
7 that some when they did were not believed. Staff were
8 largely untrained and unqualified, at least until the
9 1970s. The management structure was not conducive to an
10 environment where there was support, supervision and
11 scrutiny of staff and practice.

12 This inquiry on the evidence it has heard may
13 conclude that in the areas that I am about to discuss,
14 Quarriers' systems were not sufficiently robust.

15 The first of those areas is recruitment. There are
16 regrettably few existing employee records available from
17 which to assess the processes by which staff were
18 recruited before the 1990s. From the available
19 information, it seems that in the early years, staff
20 were recruited on the basis of their good Christian
21 character and their love of children. Over the years,
22 efforts were made to require qualifications, experience
23 and references other than from a local minister or other
24 character referee.

25 LADY SMITH: I suppose that's a stated love of children.

1 There's no evidence, for example, of any real assessment
2 being made of whether somebody who says, "I just love
3 children and want to work with them", really did feel
4 that way about children.

5 MS DOWDALLS: Indeed, my Lady.

6 Over the years interviews do appear to have taken
7 place, but they certainly were not thorough, and that
8 perhaps was an opportunity to explore just the sort of
9 issue that your Ladyship has just raised and perhaps an
10 opportunity missed.

11 By at least the 1960s, there is evidence that
12 Quarriers was obtaining references from previous
13 employers. From around that time, there is evidence of
14 police checks being carried out on potential volunteers,
15 but there are no records, however, that show that
16 similar checks were carried out in relation to
17 prospective employees.

18 From the 1990s onwards, police carried out SCRO and
19 required police checks in relation to potential
20 employees.

21 The next area is that of training. Until the 1960s,
22 from the evidence, it would seem that training was
23 largely provided by other house parents. New recruits
24 shadowed more experienced colleagues, though the
25 evidence of that was somewhat patchy from those

1 house parents who have given evidence.

2 LADY SMITH: And it depended what they were doing. For
3 example, we had some evidence of the shadowing being
4 a matter of a few weeks -- I think this was Mr Dunbar --
5 and it was nothing to do with how you look after the
6 children, but it was to do with things like when you put
7 the laundry out and what goes where in which cupboards.

8 MS DOWDALLS: Yes. That is part of the patchiness, my Lady:
9 there was no consistency in the approach to training at
10 that time.

11 That approach to training, of course, may for
12 obvious reasons have resulted in the perpetuation of
13 poor and sometimes abusive practices. During the 1960s,
14 the need for more formal structured training became
15 apparent. This was highlighted in the 1965 Home Office
16 report already discussed and the recommendations of
17 which were communicated to Quarriers.

18 In 1965, Bill Dunbar, who had obtained a childcare
19 qualification in 1961 and 1962 at Langside College took
20 over responsibility for staff training. His evidence
21 was that in-house staff training was available initially
22 and that, in about 1971, training was by secondment to
23 Langside College.

24 The training that was given, however, was not
25 compulsory. Mr Dunbar's evidence was that he didn't

1 recall resistance from staff to attendance at training,
2 but the staff who gave evidence during this inquiry --
3 was that many perhaps chose not to attend. It doesn't
4 appear from the evidence that very much was done by
5 management to encourage attendance and certainly there
6 was no compulsion to do so. There was evidence of
7 improvements in relation to training throughout the
8 1970s, however.

9 On the question of supervision, it has been noticed
10 during the course of this case study that Mr Mortimer,
11 Joseph Mortimer, held the post of superintendent at
12 Quarrier's Village for a lengthy period from 1965 until
13 1991. In that role, he was solely responsible for the
14 supervision of all of the house parents and the domestic
15 staff.

16 The evidence also showed that house parents had
17 a great deal of autonomy in the way that the cottages
18 were run. Some were able to successfully resist
19 social work intervention or scrutiny with, it seems, the
20 approval of management.

21 There was evidence of good cottages and bad cottages
22 at Quarrier's Village and accounts of happy memories in
23 some cottages. One of the former residents described it
24 as being "like a normal house".

25 That evidence demonstrates the inconsistencies among

1 house parents as to their practices, but also the lack
2 of clear standards set by management for the care of the
3 staff and a lack of adequate supervision and monitoring
4 of staff.

5 Historically, the Ladies' Committee was established
6 in 1959 to provide some external supervision. It
7 appears from the evidence that that supervision related
8 more to the physical environment in the cottages than to
9 the care of the children. I pause to observe that there
10 were some successes there, for example we've heard
11 evidence of the introduction of washing machines which
12 assisted the work of the house parents.

13 There was evidence of a lack of adequate engagement
14 by way of visits to children by local authority
15 social workers. It is notable that in that regard that
16 by the 1970s, following the enactment of the Social Work
17 (Scotland) Act 1968, most of the children placed at
18 Quarriers would have been the responsibility of the
19 local authority, which had certain duties in respect of
20 those children, including a duty to visit on a regular
21 basis.

22 On the matter of guidance and instruction of
23 house parents, as I mentioned earlier, some was provided
24 to house parents in relation to corporal punishment, and
25 your Ladyship will remember the evidence in that regard

1 going back as far as 1937. There is, however, little
2 evidence of other substantial guidance being provided to
3 house parents as to how they ought to manage and run
4 their cottages.

5 On the question of support for house parents, staff
6 to children ratios were poor in the days of
7 Quarrier's Village with limited support for
8 house parents. That appears to have improved over the
9 years with the employment of assistants and domestic
10 staff. The ratios of staff to children were, by current
11 standards, woefully inadequate.

12 By the 1960s, a psychologist had been appointed and
13 a social work department had been established which
14 provided some support for house parents. It is
15 acknowledged that this lack of adequate support however
16 may have led or contributed to poor childcare practices.

17 It is notable that at Southannan, which opened in
18 1978, the ratio of staff to children was higher and it's
19 observed that the children looked after there had
20 recognised significant behavioural issues.

21 On the matter of complaints, my Lady, from the
22 available evidence it is reasonable to conclude that
23 while it was possible for children to complain to
24 Mr Mortimer, few of them actually did so. Something has
25 been said of the open-door policy and whether it existed

1 or not. There was, in my submission, adequate evidence
2 that the policy, the open-door policy, existed, but
3 equally adequate evidence that few children chose to go
4 through the open door.

5 LADY SMITH: Yes. I think we had -- I may be wrong about
6 the witness, I think it was Joanna Brady, who gave
7 a very clear description of how daunting it would be for
8 the average child actually to go to that, going through
9 those polished doors into a place that had polished
10 brass and more dark wood, and you had to get past the
11 secretarial staff to actually get to Mr Mortimer.
12 It would take a pretty brave child to decide they were
13 going to do that, particularly having had to first of
14 all explain to the house parents where they were going.

15 MS DOWDALLS: Indeed, my Lady. While Mr Mortimer may have
16 been well intentioned in that regard, he perhaps didn't
17 recognise the remoteness of his position from the lives
18 and the position of the children that he was looking
19 after.

20 There was, however, evidence that some young people
21 complained or told individuals about abuse or abusive
22 practices, but there was no effective action taken.
23 There were repeated suggestions in the evidence,
24 my Lady, that children were simply not believed. While
25 that may be correct as a generality, there are also

1 examples in the records of children's complaints of
2 abuse being taken seriously and followed up.

3 On record-keeping, my Lady, regrettably the records
4 for children at Quarrier's Village and at Overbridge
5 held minimal information about the child or his or her
6 time in care during the period up to the 1970s.

7 Quarriers recognises the importance to former residents
8 of obtaining records of their time in care. Some former
9 residents complained during their evidence that records
10 provided to them had been incomplete or sparse. In some
11 cases, regrettably, there is nothing more that can be
12 produced. In others, details of a child's stay at
13 Quarriers or Overbridge are contained in family files or
14 sibling files which have since been recovered. Many
15 former residents have now been provided with additional
16 material and with fuller records.

17 The safeguarding and aftercare team at Quarriers,
18 headed by Mr Coggrave, has worked hard to recover,
19 collate and provide records to former residents who
20 request them. It was apparent at times during this case
21 study that witnesses had not received all of the records
22 they might have done. Where possible, Mr Coggrave or
23 Alice Harper took the opportunity after the witness had
24 given evidence to discuss those matters with them and to
25 arrange to meet with them so that fuller records and

1 possibly also photographs could be provided.

2 The records at Southannan and latterly Seafield were
3 more detailed, as one might expect given the nature of
4 those establishments, the needs of the residents and the
5 periods during which those establishments operated.

6 I have mentioned the 1965 Home Office report,
7 my Lady, and I'll say a little bit about that now. In
8 January 1965, the Home Office produced a report
9 following up on an inspection of Quarrier's Village.
10 I was reminded of the length and detail in that report
11 last night, in fact, when I re-read it. The report was
12 highly critical and it contained recommendations for
13 improvements across a wide range of issues at
14 Quarrier's Village. The report itself wasn't provided
15 to Quarriers at the time, though the recommendations
16 were communicated in 1965 to Dr Davidson, who was the
17 general director at that time.

18 In December 1965, a further visit was made,
19 a further inspection visit, and at that time it was
20 noted that some improvements had been made following the
21 recommendations.

22 In September 1966, the Scottish Education Department
23 wrote to Quarriers confirming that many of the
24 recommendations contained in the 1965 report had already
25 been implemented and that others were receiving

1 attention.

2 By 1968, a report to the Chief Inspector of the
3 Scottish Education Department noted that most of the
4 recommendations of the 1965 report had been implemented.

5 In the more lengthy detailed written submission,
6 my Lady, I have listed some of the improvements that
7 were made following upon receipt of the 1965 report at
8 Quarriers.

9 I will move on, if I may now, my Lady, to discuss
10 responses by Quarriers to allegations of non-recent
11 abuse. From 2000 onwards, there were criminal
12 prosecutions arising from complaints of abuse by former
13 Quarriers residents. As already discussed, these
14 resulted in a number of convictions. In addition,
15 a large number of civil claims for damages were
16 intimated by former residents. In her evidence,
17 Mrs Harper explained the difficulties faced by the
18 organisation at the time and some of the reasons for its
19 responses at that time.

20 It is acknowledged that some survivors have
21 criticised the responses as inadequate. Particular
22 criticism has been directed at the apology issued on
23 behalf of Quarrier's Village by Phil Robinson, then CEO,
24 in 2004 to the Petitions Committee of the
25 Scottish Parliament. The context in which Quarriers and

1 Mr Robinson were working at the time is fully explained
2 in his evidence on Day 90 of this case study.

3 In relation to the apology, his evidence was that
4 issuing a qualified apology was, as he put it,
5 "a mistake".

6 In 2010, Quarriers volunteered to participate in the
7 pilot forum, which was known as Time To Be Heard, which
8 reported in 2011. This inquiry has heard evidence from
9 Tom Shaw on Day 115 in relation to the setting-up of the
10 forum, its conduct and the evidence considered and his
11 conclusions were explained in his evidence.

12 In closing submissions, INCAS has queried what was
13 done with the SIRCC report that was commissioned by
14 Quarriers in 2001 as part of its response to the
15 allegations of non-recent abuse and has queried why that
16 report wasn't made public.

17 The reasons for that decision lie with SIRCC, which
18 is now CELCIS, and Quarriers' current management team
19 are not aware of the reasons for that decision.

20 LADY SMITH: I thought that was the case, Ms Dowdalls. It
21 was said that they were just told that it wasn't going
22 to be -- when I say they, Quarriers were told it wasn't
23 going to be published.

24 MS DOWDALLS: That's right, my Lady, I think the expression
25 used was it had been embargoed by SIRCC, now CELCIS, but

1 no explanation for that was given.

2 By way of explanation, the report was commissioned
3 to review current practices at that time, that is in
4 2001, and so far as Quarriers management team is
5 concerned, its recommendations have all been
6 implemented. A copy has been produced to this inquiry.

7 So far as engagement with survivors is concerned,
8 during Phil Robinson's tenure as chief executive between
9 2000 and 2010, he had extensive contact with and met
10 with FBGA and Mr Whelan. Relations between Quarriers
11 and FBGA were strained at that time. As was
12 acknowledged by both Mr Whelan and Alice Harper in their
13 evidence to this inquiry, relations between FBGA and
14 Mr Whelan on the one hand and Quarriers on the other are
15 now very much improved.

16 I will speak a little, if I may, about current
17 engagement with former residents, my Lady. Mr Coggrave,
18 who's the head of safeguarding and aftercare at
19 Quarriers, has met with former residents and children of
20 former residents outwith this inquiry. Like Mrs Harper,
21 he has been present during many days of evidence and,
22 where possible, he has met with survivors. Contact
23 information has been provided to the inquiry team so
24 that survivors who wish to contact the organisation may
25 do so and will have a direct point of contact, that

1 being Mr Coggrave.

2 As a result of the efforts made by him and his team,
3 a great deal of documentation has now been recovered and
4 properly recorded and archived so that it is more
5 readily available to former residents and their
6 families. He explained in his evidence the restrictions
7 placed on the organisation as a result of GDPR and the
8 organisation's response to that, which is to keep
9 redaction to a minimum and produce as much as possible.

10 Frequent requests are made for recovery of records
11 and Mr Coggrave and his team aim to respond as quickly
12 and fully as possible to those requests. He aims to
13 meet with individuals where possible to discuss and
14 disclose records and other information relating to them.
15 At times, allegations or disclosures of abuse may be
16 made by former residents. Some also require support
17 from other agencies. Quarriers' response is to signpost
18 them to other agencies as appropriate and also to report
19 to the police if there is an allegation of abuse.

20 It is acknowledged by Quarriers that its engagement
21 with former residents and ability to provide records was
22 not formalised or structured until after 2000.
23 Quarriers has invited anyone who has been disappointed
24 with past responses to contact the team now so that the
25 fullest possibly information and assistance can be

1 provided to them. Quarriers does not, however, provide
2 a support or advice service, but it will provide details
3 of such services, if required, on request.

4 During this inquiry, Quarriers has endeavoured to
5 engage fully and openly. It has supported the inquiry
6 in its work to date and it will continue to do so as the
7 inquiry moves to later phases.

8 During this case study and earlier stages, Quarriers
9 has ensured that members of its senior management team
10 have been present to hear opening statements and
11 evidence. They've been able to witness at first-hand
12 the distress of survivors and their dignity. They've
13 communicated with survivors who have been willing to
14 speak to them and they've been able to respond to
15 requests for information, apologies or acknowledgement
16 of past failures. In addition, Mrs Harper has read all
17 of the applicant statements which have been disclosed.

18 It has been made clear during the inquiry that
19 Quarriers is willing and able to communicate with
20 survivors and will facilitate such communication. As
21 I have said, contact details have been provided to the
22 inquiry team, and every effort will be made to provide
23 former residents with records of their time at
24 Quarriers.

25 The importance for survivors of having photographs

1 from their childhoods is acknowledged. This was
2 an issue that was first raised in the Time To Be Heard
3 report and Quarriers has in recent months been working
4 towards the task of collating and indexing its extensive
5 archive of photographic material and it hopes to be able
6 to provide former residents with photographs from their
7 childhood in early course.

8 Quarriers acknowledges that this matter has not been
9 dealt with as quickly as it could have been but assures
10 former residents that it is now being progressed.

11 As Mr Coggrave explained in his evidence and in his
12 statement, one impact of the inquiry process has been
13 the thorough search for records. Numerous sources have
14 been checked and these are set out in full in the fuller
15 written submission. Records have been recovered from
16 many sources.

17 The Quarriers safeguarding and aftercare service was
18 established during the course of the inquiry with
19 particular responsibility for records, communications
20 with former residents and others in connection with the
21 inquiry, or requests for information dealing with
22 disclosures, including reporting to the police and
23 development of policy in that regard, and cooperation
24 with this inquiry including the production of documents
25 and responses to Section 21 notices.

1 I will say something about the current organisation
2 moving forward and then some concluding remarks,
3 my Lady.

4 Quarriers' current services, including services for
5 children, are discussed in detail in Mr Coggrave's
6 statement. The organisation's focus on children's
7 residential services is now significantly reduced,
8 although two are maintained for children with complex
9 needs at Rivendell and Countryview within
10 Quarrier's Village. Other children's services are
11 located outwith Quarrier's Village and include support
12 services for young people, advocacy and advice services
13 and foster care services. Currently, 100% of Quarriers
14 regulated children services are rated good or above by
15 the Care Inspectorate.

16 The current management and organisational structure
17 is set out in an appendix to Mrs Harper's statement. It
18 is a line management structure with ultimate
19 responsibility resting with her as CEO and she is
20 answerable only to the board of trustees.

21 Staff recruitment policy is the responsibility of
22 the HR department, the department for learning and
23 talent development is responsible for training and
24 oversight of staff development and qualifications. The
25 roles of each of these departments are discussed fully

1 in Mr Coggrave's statement.

2 Quarriers is proud to have recently been awarded the
3 platinum Investors in People award, which is
4 a significant achievement for the organisation.

5 What's apparent from the organisational witnesses'
6 statements and the documents provided showing current
7 policy and practice is that Quarriers' focus is directed
8 to caring and safeguarding effectively, compassionately
9 and with respect for the people it supports and their
10 families in a professional environment.

11 Quarriers has welcomed this inquiry and the lessons
12 learned from listening to accounts of abuse and the
13 review of records and scrutiny of its own historical
14 policies and practices. Currently residential childcare
15 practice has been informed by child-centred practice,
16 GIRFEC and the associated SHANARRI framework, and the
17 work done to date in response to the inquiry, and it
18 will continue to evolve in the future.

19 The inquiry has heard evidence of changes in policy
20 and practice, including areas such as: physical
21 punishment, which is no longer tolerated in Quarriers
22 establishments; restraint, which is subject to complex
23 procedures including assessment, avoidance and use of
24 alternative strategies; bed-wetting, which is recognised
25 as a sign that a child may require help or support, and

1 is responded to privately and with sensitivity and
2 compassion; force-feeding, which is not tolerated,
3 children are encouraged to eat and issues surrounding
4 food relating to a particular child will be flagged up
5 in their care plan; contact with family and other
6 visitors, which is positively encouraged having regard
7 to the welfare of the child; birthdays and other
8 celebrations which are marked appropriately having
9 regard to the child's needs and ethic and religious
10 background.

11 Notwithstanding the improvements that have been
12 made, professionals experienced in the area of
13 residential childcare recognise that further progress
14 could be made. Witnesses from Quarriers, Aberlour and
15 Barnardo's, all with extensive experience in the field,
16 suggested possible improvements. Those include
17 reduction of training periods for childcare
18 professionals, although such changes were largely
19 considered not to be practical in the current labour
20 market; increased or increasing funding of services;
21 promoting greater respect for the social and residential
22 care profession.

23 Mr Coggrave suggested that a single point of contact
24 with other services, such as the police, medical and
25 educational authorities and local authorities, would

1 improve communication and information sharing.

2 In his statement at paragraph 191, he refers to
3 efforts made to obtain a police liaison officer. His
4 view is that it would be helpful to have a central point
5 of contact within Police Scotland to whom information
6 about disclosures of abuse could be communicated.

7 It is sadly unlikely that whatever safeguards are
8 put in place, the risk that a child will be abused by
9 those caring for them will be completely eliminated.

10 Mr Coggrave in his evidence put it this way and I quote:

11 "Folk that want to abuse children are well motivated
12 and creative in my experience."

13 The realistic goal therefore is to take all steps
14 necessary to reduce the risk of abuse as far as
15 possible. The evidence led in this inquiry suggests
16 that the key is to focus on training and qualification
17 of care staff, having robust child protection policies
18 and practices, developing staff and service user
19 awareness of what amounts to abuse through education, so
20 that staff in particular are alert to signs of abuse;
21 and developing and maintaining effective whistle-blowing
22 policies within an effective management structure that
23 will ensure concerns are taken seriously and acted upon
24 swiftly. The importance of listening to children and
25 facilitating the expression by them of their views

1 cannot be underestimated and should form the central
2 focus of child protection and childcare work.

3 In conclusion, my Lady, Quarriers' current
4 management acknowledges the importance of the inquiry to
5 survivors and residential care providers. During this
6 case study, former Quarriers residents have come forward
7 to describe, sometimes in intimate detail, events that
8 are deeply personal and often distressing. Many were
9 willing to speak with Quarriers current management team
10 after they'd given evidence. Quarriers is grateful to
11 them for their candour and courage and for the
12 respectful way that they engaged with Quarriers
13 representatives during the case study.

14 Quarriers management looks forward to the inquiry
15 chair's report and recommendations. It is important for
16 those who provided residential care to children in the
17 past and those who do so now to learn from the mistakes
18 of the past and use the knowledge acquired during this
19 process to improve services for the future.

20 Unless I can be of any further assistance, my Lady,
21 that concludes my submission on behalf of Quarriers.

22 LADY SMITH: Thank you very much, Ms Dowdalls. Thank you
23 for the care and detailed attention you given to all the
24 issues that needed to be covered in your submission.

25 I would like to turn now, if I may, to the closing

1 submissions on behalf of Barnardo's. Mr Jackson is here
2 for those. I doubt that you'll finish them by
3 1 o'clock, Mr Jackson. If you're running up to
4 1 o'clock and you still have a bit to go, please find
5 a convenient stopping place that suits you and we'll
6 rise then.

7 Closing submissions by MR JACKSON

8 MR JACKSON: Thank you.

9 Let me say immediately on behalf of Barnardo's the
10 desire to recognise and respect evidence that we've
11 heard from all the applicants who were formerly in their
12 care. They have shown great courage to coming forward
13 to the inquiry at all and even more in giving evidence
14 in public. We appreciate how difficult that has been
15 for those who have suffered abuse, having to relive
16 their experiences and share them in a public forum.

17 Equally, I am conscious that Barnardo's have tried
18 to cooperate fully with the inquiry. A great deal, over
19 many months, has been submitted in writing, in closing
20 submissions, and I'm grateful to my Lady for allowing me
21 to have mine just in this morning for other reasons, and
22 in oral evidence.

23 All that material is now before the inquiry and
24 I would see little value in repeating all of that here.
25 I do, however, want to focus just on certain issues and

1 to make clear submissions on, firstly, the abuse that
2 the applicants courageously spoke about and, secondly,
3 a few more issues of general interest.

4 When we come to look at abuse, we can I think fairly
5 divide it into two categories. There is sexual abuse
6 and other abuse which itself can take a variety of
7 forms, both physical and emotional, and no less
8 important.

9 It has often been said that the latter, that is the
10 more physical abuse, can to some extent be at least
11 partially understood in the context of the then
12 prevailing norms. Let me be clear: I'm not hiding
13 behind that in any way, shape or form. The fact that
14 there were different prevailing norms does not condone
15 certain behaviour.

16 I also accept that the fact that something would be
17 acceptable in school -- I mean day school in the normal
18 sense -- or in a family home does not necessarily mean
19 that should equally apply to those in residential care.
20 They are not entirely the same.

21 It must also be the case that excessive and
22 inappropriate use of corporal punishment would be an
23 unacceptable form of abuse at any time.

24 Having said that, sexual abuse, on the other hand,
25 stands in a different category. At no time would that

1 or should that have ever been condoned in any shape or
2 form. No amount of reference to prevailing norms has
3 any relevance to sexual abuse.

4 Having said that, I want to look briefly at the
5 allegations of abuse which have been given in evidence.
6 Sexual abuse did take place. One former member of staff
7 has been convicted. Other applicants have given
8 evidence that they too suffered in this way without my
9 rehearsing the detail.

10 Having said, as I will say over and over again that
11 these things should never have happened, it might be
12 worth asking why they were allowed to take place at all.

13 We now live in a time when such abuse is widely
14 known to have happened. Indeed, our criminal courts
15 these days seem to be dealing with almost nothing else.
16 That was not always the case. For most people, such
17 behaviour was, in the past, unthinkable. I think we
18 even heard from members of staff who didn't know the
19 meaning of certain words that would now be commonplace,
20 such was the atmosphere at the time, and the thought
21 that fellow staff members might be behaving in these
22 sort of ways was simply not contemplated.

23 Interestingly, even when there were suspicions --
24 and from time to time people had suspicions about
25 others -- there was a reluctance to give voice to it,

1 not I suggest purely because of being
2 anti-whistle-blowing; it was partly because the whole
3 idea was so unthinkable that it was very difficult to
4 face up to. That excuses nothing, but it does perhaps
5 give some understanding of how these things happened.

6 But its very nature, such activities were carried
7 out in secret, often under the pretence of forming
8 a healthy and helpful relationship with the child. In
9 some ways that's been one of the saddest things we've
10 heard: of children who were grateful for the attention
11 given them and being taken on outings and felt they were
12 getting a much-needed attention --

13 LADY SMITH: It's a very common reaction amongst children,
14 particularly during the grooming period, when it was
15 something nice that was happening in their lives when
16 everything else was so tough.

17 MR JACKSON: And the tragedy was that was on occasions
18 overlaid with this much more sinister aspect of
19 behaviour, but that made it all the more difficult
20 perhaps to identify without the benefit of hindsight.

21 It's also true to say that systems which would
22 safeguard against such behaviour were simply not in
23 place in the way they are today. I make no excuse for
24 that, it's not peculiar to Barnardo's, but it is
25 undoubtedly a fact of the time.

1 But if I could also think about more general terms
2 of abuse which have been mentioned. A number of issues,
3 I just mention them in passing to some degree, have been
4 mentioned.

5 Physical abuse. Although I say, and I have said
6 that, corporal punishment has to be set in the context
7 of the times, I say again it is totally accepted that at
8 any time excessive or improper use of corporal
9 punishment was unacceptable and abusive.

10 LADY SMITH: There's also a category of, let's call it
11 physical force, amounting to abuse of children being on
12 the receiving end of it when it wasn't a punishment for
13 anything at all; that is just the way they were treated.

14 MR JACKSON: Indeed, and I do not make light of that in any
15 way, shape or form. Barnardo's supplementary statement
16 contains the up-to-date information as to the number of
17 allegations of abuse that they have received and
18 Barnardo's is aware of allegations over and above those
19 made directly to the inquiry.

20 None of this was acceptable in any era. It did not
21 reflect what Barnardo's expected of care staff, nor what
22 was set out in guidance to them. It ought not to have
23 happened.

24 Your Ladyship has also heard from applicants,
25 members of staff, who did not see that sort of thing.

1 That of course did not mean it did not happen.

2 Witnesses gave such evidence that they had neither
3 seen it nor heard of it happening to others and
4 of course it needs perhaps to be said that some staff
5 members have specifically refuted allegations made
6 against them.

7 There was detailed evidence from former staff,
8 ranging from evidence that in the 1960s corporal
9 punishment was used sparingly, albeit considered
10 acceptable at the time. In the 1970s, there was an
11 unwritten code of conduct that there was to be no
12 corporal punishment, and in the 1980s and 1990s,
13 corporal punishment was prohibited and not to be used,
14 no doubt as my Lady pointed out to others, in response
15 to a European-wide change in how we dealt with these
16 things.

17 But I do suggest and submit that Barnardo's approach
18 to corporal punishment was generally progressive and was
19 the subject of regular review. It was restricted to
20 a level below that permitted by the legislation of the
21 day. There was a requirement to keep punishment books
22 but those have not been retained for any Scottish
23 establishment. There was requirement for each home to
24 report their use of corporal punishment and these
25 reports were monitored.

1 The 1944 and 1955, Barnardo's Books stipulated that
2 copies of the punishment book were to be sent to
3 headquarters once a week. Barnardo's has produced
4 minutes of staff meeting from the early 1970s. From the
5 sample of management records showing that management
6 emphasised that regular signing of punishment books was
7 to be carried out by senior residential officers.
8 Having said all that, we accept that this system was not
9 foolproof. The centralised approach which was good,
10 which was progressive, was not foolproof against
11 individual members of staff using excessive or
12 inappropriate punishment and failing to report it.

13 If I could say something about bed-wetting, which
14 I certainly found a particularly distressing episode,
15 because I think most of us would accept that being
16 struck is one thing, being humiliated is quite another
17 thing, and while I don't make comparisons between them,
18 there is something particularly horrid about the latter.

19 There was a divergence of evidence in the case of
20 Barnardo's and from applicants and former members of
21 staff regarding the response to bed-wetting and the
22 bathing routine for children. That might simply reflect
23 differences in practice between homes in different
24 areas. It may just be geographical. So you had
25 evidence in some places of good practice, but of course,

1 for example, staff waiting until a child had gone to
2 school so that the child would not be embarrassed by
3 sheets being changed, but of course there was also
4 evidence of unacceptable practice and that cannot be
5 avoided.

6 Barnardo's would want to apologise to every child
7 who was ever punished for wetting the bed or was ever
8 placed into a humiliating situation by the manner in
9 which it was dealt with by staff at the time.

10 I'm also submitting, I hope correctly, that at least
11 generally there was no suggestion that this was done
12 with malicious intent. This, however, is a clear area
13 where understanding and attitudes have changed over
14 time, and if I may say so, for the better.

15 Punishment for wetting the bed was prohibited.
16 Specifically in the 1944 and 1955 Barnardo's Books,
17 children ought not to have been punished for this and
18 when it did it was contrary to Barnardo's guidance and
19 acceptable practice.

20 One of the more difficult areas, if I may call it
21 that, is restraint and I noticed that when Mr Peoples
22 dealt with his submissions, he tended to give restraint
23 a fairly wide berth because it is even yet an area that
24 provokes discussion.

25 I suppose it is clear that on occasions restraint

1 will always be necessary. If a member of staff is being
2 approached by a fit, healthy teenage male holding an
3 implement, you would be difficult to judge any action in
4 an over-theoretical manner. That is an extreme example,
5 but it does illustrate how difficult this area can be.

6 Having said that, it is appropriate to prepare as
7 far as possible for such situations and to have relevant
8 systems and institutions in place. A number of members
9 of staff, senior members of staff, such as
10 Hugh Mackintosh, Sir Roger Singleton, have mentioned
11 these sort of areas and the reality is that the present
12 practice recognises this much more than it did.

13 In the early years there was little training on
14 restraint, training was on the job, latterly two
15 techniques were taught. Children were not being
16 restrained in the same way across all units and, even by
17 2005, there was no clear national guidance on best
18 practice and indeed there was a reluctance to be
19 over-prescriptive. Training was given in some places to
20 reflect the current thinking at that time, but I think
21 it is fair to say that staff were aware of the principle
22 of using as little force as was necessary and to only
23 use restraint when it was necessary to prevent physical
24 injury to the child/young person or serious damage to
25 property.

1 The reality is this will always be a difficult area
2 because restraint to some extent will never be totally
3 avoidable, but it is important and we recognise that
4 proper procedures need to be put in place.

5 All of that having been said, having accepted that
6 there were things both of a sexual and non-sexual nature
7 that should never have happened, and for which
8 Barnardo's unreservedly apologises, it remains in my
9 submission a very important issue. How is this
10 undoubted abuse to be properly characterised in relation
11 to Barnardo's generally as a long-term care provider?

12 We use occasions -- and I make no criticism and I'm
13 not suggesting this has ever been said about
14 Barnardo's -- phrases such as "widespread abuse", "part
15 of everyday life", "an underlying culture of fear". All
16 I would say is that would, in my submission, not be
17 a fair characterisation of the care given by Barnardo's.
18 That is not in any way to be complacent or to minimise
19 the traumatic effect of any form of abuse on any one
20 child, but terms such as I have used suggest something
21 very badly wrong at the core of the organisation. That
22 I do say again would not be a fair representation of
23 Barnardo's.

24 In my submission, the evidence taken fairly and as
25 a whole, taking, in the words of Mr Peoples, the broad

1 picture, shows a caring, compassionate organisation with
2 dedicated staff doing their best in the best interests
3 of the child.

4 The accepted fact -- and I totally accept it -- that
5 over a very lengthy period and over many thousands of
6 children, things happened that clearly should not have
7 happened, mistakes made which should not have been made,
8 systems not followed always as they should have been,
9 inevitable human error and, on occasion, utterly wrong
10 behaviour, should not allow sight to be lost of the
11 general care, compassion of the staff of all that
12 organisation.

13 That is why we have included a section on positive
14 aspects of children's times at Barnardo's. It is a long
15 list. One example will suffice, about South Oswald
16 Road. One applicant said:

17 "This was a brilliant place. It felt like going
18 back home to my home. Sheila and Lewis Currie ran the
19 place and were the most fantastic couple you could ever
20 meet. They were absolutely brilliant."

21 Let me be absolutely clear what I'm saying. That is
22 not meant to balance the abuse. I do not say that in
23 order to negate abuse because if it happened, it should
24 not have happened, but I do say it recognises that there
25 was much that amounted to appropriate care and support

1 for those in care.

2 Against that background, I would like briefly to
3 turn to some other issues which are related to the
4 inquiry such as training, aftercare, et cetera, and as
5 it's 12.55, I might just call a halt at that, if I may.

6 LADY SMITH: Very well. I will rise now for the lunch break
7 and sit again at 2 o'clock. Thank you.

8 (12.56 pm)

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

(The lunch adjournment)

(2.00 pm)

LADY SMITH: Mr Jackson, when you're ready.

MR JACKSON: Thank you.

My Lady, having dealt with perhaps the core issue of abuse in its various forms and having tried to put that in a broad context, I would just turn briefly to a few other related issues which have arisen during the course of the inquiry. They're all dealt with at some length in the written submission, but I simply mention a few of them.

One is, of course, recruitment and training. Your Ladyship heard evidence from former members of staff as to the process and the training they received following recruitment. From the 1940s to the 1960s, head office was heavily involved in that process, but from the 1970s there was a gradual devolution of authority to senior management in order to add an additional level of scrutiny.

Many could not recall formal induction and it is certainly the case that throughout the time period training was very much on the job, it involved shadowing other members of staff.

Some staff did receive more detailed training.

1 Barnardo's organised training programmes for residential
2 care staff and things like in-service training days, and
3 Sir Roger Singleton gave us evidence on that matter. As
4 he pointed out, although a significant number of
5 courses -- not a large number of courses -- were run, as
6 there were 30,000 people working in the sector, he did
7 concede that that was a drop in the ocean.

8 I think it is fair to say, though, that Barnardo's
9 recognised the importance of training at an early stage.
10 It provided accredited training courses as far back as
11 the 1940s. The nature of work was such to prevent the
12 release of all staff for that and priority was given to
13 training senior staff.

14 External training courses were very restricted
15 in the numbers they could train compared to the numbers
16 employed and that may well have been linked to the fact
17 of the issue with retention of staff. What I think came
18 across quite often in evidence was the lack of
19 appreciation given to people who were employed in that
20 sector.

21 Someone I remember giving evidence -- I don't think
22 they were from Barnardo's -- said they had been in the
23 sector for 30 years only to be met with the response,
24 "Hardly a career, is it?" So that kind of background
25 and those kind of attitudes obviously did not help.

1 Despite all that, Barnardo's has always been -- and
2 I will qualify this in a moment -- at the cutting edge
3 in terms of recruitment and training, and they were
4 fortunate in the quality of staff they had. I say that
5 because I think someone else described it this morning
6 as patchy, and I accept that of course because things
7 were compared to how they were now patchy. But it
8 doesn't take away my position that training was always
9 something at the forefront of Barnardo's management's
10 mind and a great deal was done, albeit one could always
11 have done it more or done it better.

12 LADY SMITH: The word patchy was used by a Barnardo's
13 witness, I think, Mr Jackson.

14 MR JACKSON: Indeed, but I think it might have been repeated
15 this morning.

16 LADY SMITH: It was referred to this morning, yes.

17 MR JACKSON: And I don't take away from that. I, of course,
18 accept that that's an accurate way of putting it.

19 So far as record-keeping is concerned, Barnardo's
20 has historically kept detailed records for all in its
21 care and that was highlighted in a 1944 Barnardo's Book.

22 From 1942 each child admitted had their own paper
23 file held at headquarters and at the regional office in
24 Edinburgh. They were returned when the child was 18 to
25 head office for archiving and have been microfilmed or

1 scanned to the appropriate technology.

2 The various regulations which came in were reflected
3 in Barnardo's procedures being updated.

4 So there has been a quality of record-keeping which
5 could be said to be good throughout the period when
6 judged, again of course, by record-keeping practices
7 at the time. We also recognise, of course, that the
8 quality of those records is not always what it could
9 have been.

10 In particular, staff had limited awareness of
11 a child's history. On reflection, that was a pity.
12 There was sometimes limited guidance on what to include
13 in daily records, so staff would sometimes record, as
14 they saw it, major events but not necessarily day-to-day
15 events.

16 But suffice it to say, Barnardo's has long
17 understood the centrality of a child's record and has
18 tried to maintain an archive made available to all
19 former children and to the families of those who have
20 since died.

21 Barnardo's still carefully considers how best to
22 support those who request records. They allocate
23 social workers as part of the preparation work to
24 identify areas in those records which may cause
25 distress. Sometimes that's the language used in the

1 records. And those who are getting their records are
2 given support before and after the reading of such
3 records.

4 About 50% of people still come in person to get
5 their records face to face and a duty of care is always
6 undertaken before any records are released.

7 In the course of this case study, my Lady will
8 remember one applicant requested records and they were
9 then made available, I think, in quick time along with
10 various photographs of when the person was in care, and
11 I think it's fair to say that applicant was delighted
12 with what was done in response to that request.

13 When it comes to aftercare, there have been
14 differing views. Some applicants felt they were not
15 given sufficient aftercare. I would simply refer you to
16 the evidence of Kate Roach, the service manager of
17 Making Connections at Barnardo's, who gave, I suggest,
18 very detailed and very helpful evidence to the inquiry.
19 The sum and substance was that Barnardo's was and is
20 committed to the ongoing support of young people in its
21 care and the Barnardo's Book always took that very
22 seriously.

23 It was absolutely the case, she says, that when the
24 older boys and girls left Barnardo's there was never any
25 question of them simply leaving Barnardo's care. It was

1 always made clear they would remain part of the
2 Barnardo's family.

3 Again, nothing would be perfect and, of course,
4 would depend on the young person to a degree. Some
5 people welcomed the support, some people wished to cut
6 ties, but I do suggest that the evidence given by
7 Kate Roach does give a very good picture of how
8 seriously and still does take seriously that sort of
9 aftercare provision is made.

10 Where an allegation of historic abuse is made today,
11 a number of steps are taken. These are discussed quite
12 fully in the written submissions. But
13 Making Connections will review the records to find
14 circumstantial evidence, the names of members of staff,
15 and put it into some sort of context. There is also
16 maintained a historic abuse database which they can
17 search by home to find all allegations made in respect
18 of staff or residents at that home. They can tell
19 individuals that they were not alone in making
20 allegations about a particular individual if the
21 database reveals that that was indeed the case.

22 What is to be emphasised is the last thing the
23 Making Connections team are doing are looking to
24 disprove any allegations made. That is very, very much
25 not what they are about. They are there to try and

1 assist and to help and to giving a continuing support.

2 Barnardo's -- and I think this is fair -- has always
3 recognised the importance of providing children with
4 aftercare. It provided a service perhaps before other
5 organisations were in a position to do so and would
6 continue to provide ongoing support for former
7 residents.

8 So in conclusion, let me just say this: Barnardo's
9 approach -- and this has been spoken to by a number of
10 witnesses to residential childcare -- far from perfect,
11 was head of its time in many respects, constantly
12 reviewed, updated to respond to legislative changes and
13 to research improvements, knowledge and best practice.
14 And Barnardo's has tried to keep abreast of developments
15 in the wider sector and change practice to reflect that.

16 Sir Roger Singleton gave helpful evidence on that,
17 as did John Rea and Hugh Mackintosh. Of course, no
18 system is perfect and no system can always operate
19 entirely as one would have wanted it to do, but I do
20 think it's fair to say that there has been a real
21 awareness of that as far as Barnardo's are concerned.

22 Barnardo's has, of course, thoroughly welcomed the
23 inquiry and tried to cooperate with it in every way
24 possible, responded to all requests, written
25 submissions, and having, you will have noticed, a senior

1 representative present throughout the evidence, all of
2 it relating to Barnardo's. You have heard all the
3 evidence and had all the evidence we can possibly give.

4 I have not been attempting to repeat it or even
5 summarise it, but I have tried to focus on some
6 important issues, and in conclusion, just one or two
7 things stand out.

8 Let me say again: over the long period the inquiry
9 is concerned with, abuse did on occasions occur, sexual
10 or more generally. For any of that and all of that,
11 Barnardo's apologises unreservedly. No child should
12 ever have been subjected to any form of abuse and, in
13 particular, abuse of a sexual nature.

14 Even if these were to an extent -- and I don't
15 elaborate that -- isolated incidents, that makes no
16 difference to the regret felt by Barnardo's. One child
17 abused or ill-treated is one too many.

18 It is, however, appropriate, and I have tried to do
19 that in fairness, to all concerned, to place that in
20 a general context and I believe the evidence does show
21 Barnardo's was, and indeed remains, a highly caring
22 organisation with a dedicated staff. It would in many
23 ways be a tragedy if that were ever to be lost sight of.

24 I would also underscore Barnardo's strong sense of
25 duty and commitment to listening to and learning from

1 the experience of these former residents.

2 Barnardo's has always provide an aftercare service,
3 has employed officers for that since the 1940s, and
4 of course Making Connections came into being by the
5 amalgamation of other departments in 2008. It has been
6 a central point of contact for those persons seeking
7 information about their time in care and it has been
8 there to support and to disclose where there has been
9 poor care and abuse. That will continue for as long as
10 is required and, of course, already that for some former
11 residents has been many years.

12 Barnardo's would like to think of itself as trying
13 as best it can to be in the forefront of reforming good
14 practice and it would certainly be its intention to
15 continue in the future in that vein.

16 I think everything else I might say will be in
17 a very substantial written submission which was lodged
18 this morning.

19 LADY SMITH: Thank you very much, Mr Jackson.

20 I would now like to turn to the closing submission
21 for the Aberlour Child Care Trust and invite Mr Love to
22 address me.

23 When you are ready, Mr Love.

24 Closing submissions by MR LOVE

25 MR LOVE: Thank you, my Lady.

1 Your Ladyship has a full detailed closing statement
2 prepared on behalf of Aberlour, the content of which is
3 adopted. I don't intend to read it in full and will
4 provide a summary.

5 Aberlour remains grateful for the opportunity to
6 participate in this inquiry as a core participant and to
7 present this closing statement. Aberlour neither
8 excuses nor condones the abuse of children in any form
9 whatsoever. They have offered and will continue to
10 offer every assistance to the inquiry.

11 Aberlour has welcomed the opportunity afforded by
12 the inquiry to investigate the flaws in its historical
13 procedures and practices, which may have contributed to
14 abuse perpetrated towards children in its care.

15 Board members and senior officers of Aberlour have
16 been able to attend throughout, hearing the evidence of
17 the inquiry, and have themselves witnessed and been
18 touched by the distress of survivors, their courage in
19 coming forward, and the dignity with which they've
20 conducted themselves.

21 Like any organisation seeking to promote the welfare
22 of children, Aberlour considers the abuse of children to
23 be abhorrent. During the period under consideration by
24 the inquiry, many thousands of children have been looked
25 after by Aberlour or have been able to access its

1 services. Despite some positive evidence that the
2 inquiry has heard about the positive and quality times
3 that children spent in their care, Aberlour accepts with
4 regret that there have been occasions where abuse
5 occurred and the responses sent by Aberlour to the
6 inquiry have identified all such occasions which are
7 currently known to them.

8 As was explicitly expressed at the very start of
9 phase 1 of this inquiry, in relation to any children who
10 did suffer abuse while in its care, Aberlour recognises
11 this should not have happened. It welcomes this
12 opportunity to reiterate an unreserved apology to those
13 who were abused whilst in its care and to their
14 families.

15 Indeed, in her evidence, SallyAnn Kelly acknowledged
16 and did not seek to underplay or gloss over the failures
17 of Aberlour that have undoubtedly been disclosed by the
18 evidence of applicants and she offered her own personal
19 and sincere apologies for what had occurred.

20 The assessment of the evidence is a matter for
21 your Ladyship. There are a number of specific issues or
22 themes arising from the evidence before the inquiry that
23 Aberlour would wish to address at this stage. Turning
24 first, if I may, to the issue of the separation of
25 sibling groups within the Aberlour Orphanage.

1 From 1930 to around 1955, sexes were mixed in the
2 nursery only, and when children were old enough to begin
3 school, boys and girls were separated into distinct
4 wings. The dining rooms and the dormitories were within
5 these wings and accordingly children slept and ate only
6 with other children of the same sex. Although sexes
7 were mixed in school in the usual fashion, school
8 classes were naturally organised by reference to age
9 and, to some extent, the houses within the orphanage
10 also appeared to have been organised by reference to
11 age, although the information on this is less consistent
12 and clear.

13 There appears to have been no firm policy
14 identifying a specific age at which any child should
15 move from one house to another, although it is accepted
16 that it seems to have been the norm for children to
17 change houses as they aged.

18 The separation of sexes into distinct buildings was
19 clearly policy at the time of the construction and
20 development of the orphanage, and a mix of sexes was
21 undertaken on initially a trial basis in 1955 and was
22 then the norm throughout.

23 From 1955 onwards, the mixing of boys and girls was
24 a feature of orphanage life, but, on the evidence, was
25 not consistently applied in a manner which kept siblings

1 in one house.

2 It is obvious that it would have been possible for
3 children to mix with their siblings at play and at
4 school. While there is no evidence available of any
5 policy or practice of preventing contact between
6 siblings in these settings, equally there is no firm
7 evidence of consistent action being taken with the aim
8 of sibling groups being kept together.

9 It is also accepted that there is no evidence of any
10 firm, deliberate or consistent policy or practice of
11 seeking to organise, facilitate or positively promote
12 regular and good quality contact between siblings.
13 It is accepted that this may, for some young people,
14 have resulted in their living separately from siblings
15 during most or all of their time in the orphanage,
16 possibly with only infrequent or even coincidental
17 meetings. It is accepted that this may have had
18 a detrimental effect upon the relationships with
19 siblings and for that Aberlour's sincere apologies are
20 offered.

21 In addition, the lack of any system to ensure that
22 contact details for young people leaving the orphanage
23 were made available to younger siblings hampered the
24 availability of those younger siblings to keep in
25 contact with family members who had moved on before

1 them. Aberlour accepts that in the orphanage years, it
2 did not do all that it could have done to assist those
3 siblings in building or maintaining a potentially
4 supportive family network for their future life.
5 Aberlour deeply regrets and is truly sorry for the
6 consequences of that failure and offers its apologies to
7 any young person who feels that this had a detrimental
8 effect on their family relationships.

9 Moving on to departure and aftercare, my Lady. Some
10 applicants spoke of leaving Aberlour with little notice
11 and little preparation and of having found this to be an
12 upsetting and unsettling experience.

13 LADY SMITH: There was more than one instance spoken to of
14 applicants really not knowing until the day they were
15 leaving. It's striking.

16 MR LOVE: Yes, that certainly seems to be the case, my Lady.

17 The various applicants giving evidence to the
18 inquiry left Aberlour in quite different circumstances
19 and it's readily accepted that the extent of knowledge
20 which the individual applicants had of their impending
21 departure varied. It's also readily accepted that the
22 level of preparation which individual applicants had in
23 advance of their departure varied. It is clear that the
24 level of preparation for departure was not always
25 substantial. In some cases it was plainly inadequate

1 and wholly insufficient, and sincere apologies are
2 offered for this and its consequences to those who have
3 been affected.

4 Aberlour readily accepts that some young people
5 leaving the orphanage felt that they were not well
6 prepared for adult life and the transition into their
7 future lives was not well handled. A very different
8 approach is taken to this at present, but Aberlour
9 accepts that in the orphanage years children did not
10 always receive enough advance notice of their departure
11 to allow them to feel prepared and that they had
12 appropriately taken leave of their home, something very
13 important to them, and those with whom they had lived
14 for often substantial periods of time.

15 Aberlour would like to take this opportunity to
16 extend its heartfelt apologies to any former resident
17 who at the time of leaving the orphanage, in particular,
18 did not feel adequately supported through this process.

19 Where children were placed in the care of Aberlour
20 by local authorities, the level of involvement of
21 Aberlour in planning and decision-making about the
22 futures of children they had cared for was limited as
23 that decision-making power rested with the placing
24 authority. Aberlour was not, as a matter of standard
25 practice, given a voice in those processes. Often

1 it would simply receive a letter -- your Ladyship heard
2 evidence about this -- from the placing authority giving
3 very few days of notice and advising that the children's
4 officer would arrive at the orphanage at a specified
5 time to collect and remove the young person. There was
6 evidence about two days in advance a letter being
7 received at the orphanage. This gave limited
8 information to relay to the young person and limited
9 time in which to prepare the young person for that
10 specific arrangement as opposed to preparation for the
11 general concept of moving on.

12 That said, it is accepted without qualification that
13 there is evidence before the inquiry which calls into
14 question the amount of preparatory work carried out with
15 young people to prepare them for transition into the
16 adult world.

17 LADY SMITH: Just going back to the late notice given by the
18 placing authority, unfortunately there was no evidence
19 that I heard of anybody standing up to the local
20 authority and telling them, "This will not do, we're not
21 handing children over to you on a two-day notice or
22 a same-day notice".

23 MR LOVE: Yes, certainly I'm not aware of having seen any
24 evidence to that effect, my Lady.

25 LADY SMITH: So the practice continued.

1 MR LOVE: The practice continued without obstruction or
2 criticism.

3 LADY SMITH: Yes.

4 MR LOVE: There is evidence that in the limited time
5 available after notification from a placing authority
6 had been received and before the young person was
7 removed, there was not enough done to advise the young
8 person about what was about to happen to them. It is
9 obvious that this would have been possible and it's
10 obvious that the involvement of the young person in
11 packing their clothing, gathering their personal
12 possessions, affording them the opportunity of saying
13 goodbye to their friends, to their carers and to their
14 home ought to have been afforded.

15 Aberlour readily accepts that for some children they
16 fell well short of making the best and fullest use of
17 even the limited information that they were given or of
18 the time available to them after becoming aware of an
19 imminent departure so as to best prepare the young
20 person for leaving their home. It's entirely
21 understandable that young people may have consequently
22 been left feeling confused, distressed, isolated,
23 ignored, and for that Aberlour is truly sorry.

24 Moving on to punishment. Discipline and punishment
25 are not synonymous and that has been the evidence in

1 this inquiry. Discipline is a mode of living and it is
2 distinguishable from a system of punishment. In
3 considering, in particular, advertisements for
4 employees, indicating that an ability to maintain
5 discipline is desirable, this terminology should be
6 viewed in context.

7 Further, in advertising for staff in the immediate
8 post-war period, indicating that a job would be suitable
9 for a former serviceman, it is submitted that it is
10 clear that there were significant numbers of such
11 individuals seeking gainful employment. Such
12 advertisements should be viewed in the context of their
13 times and not as implicitly indicative of a need for
14 individuals who were likely to take a militaristic
15 approach to punishment of young people.

16 LADY SMITH: I just reflect, Mr Love, on the immediate
17 impression one gets if told an ability to maintain
18 discipline is desirable and these jobs would be suitable
19 for former servicemen. It is very hard to resist the
20 impression that control is to be prioritised.

21 MR LOVE: Yes, control and to that extent --

22 LADY SMITH: Firm control.

23 MR LOVE: It shouldn't be taken to imply an expectation that
24 harsh punishment should be or would be required.

25 LADY SMITH: There's not much there about warm, loving

1 nature, for example, is there?

2 MR LOVE: Well, there's one of the advertisements that did
3 make reference, rather oddly, to the requirement that
4 somebody should be fond of children. A peculiar
5 expression, but the advertisements weren't entirely
6 devoid of giving an indication that an interest in
7 children was required, not just the militaristic
8 background of those who might seek to apply.

9 While discipline is related to the need for
10 boundaries and for conduct to adhere to particular rules
11 and values, that's not to say that the maintenance of
12 such discipline is equivalent or restricted to a system
13 of punitive measures. Discipline is capable of being
14 maintained by positive means and I think your Ladyship
15 has heard evidence about that, certainly in the latter
16 stages of the evidence.

17 For example, by the instilling of self-discipline in
18 individuals by example and by role-modelling, and by
19 giving leadership and direction towards the maintenance
20 of high personal standards, and by the development of
21 routines and structures which are conducive to the
22 standards desired.

23 Maintenance of such discipline can be conducive to
24 the development of a feeling of security for young
25 people, particularly those who have previously

1 experienced life as unpredictable or chaotic and strong
2 personal relationships and bonds can be achieved.

3 On consideration, it appears that Aberlour's rules
4 on discipline and punishment were probably in place from
5 at least the late 1940s. The content of the rules when
6 taken in conjunction with the content of discussions at
7 governors' meetings shows that Aberlour expected any
8 punishment to be applied uniformly, to be proportionate,
9 and not to be excessive.

10 Aberlour's rules outline the approach taken to
11 monitoring compliance with its policy on punishment. As
12 with other core participants, punishment books were
13 required to be maintained with black marks for minor
14 offences and all entries where corporal punishment was
15 imposed to be marked with a P. These books were to be
16 reviewed by the warden or lady superintendent at the end
17 of each week when four black marks could result in the
18 loss of pocket money for one week or two. This ought to
19 result in the awareness of senior management of all
20 recorded punishments.

21 There are several instances, such as the
22 reprimanding of BCK, for engaging in an
23 excessive degree of corporal punishment which, it is
24 submitted, demonstrates the commitment of Aberlour to
25 ensuring that their policy was followed through in

1 practice.

2 That commitment and what appears to have happened
3 based on the evidence of applicants diverged because
4 it's clear on the evidence that punishments well beyond
5 those set out in the rules were administered, and to any
6 child who experienced punishment in the care of Aberlour
7 which was inconsistent with the policy system which had
8 been created and sought to enforce, sincere apologies
9 are offered.

10 There has been evidence about enuresis and issues
11 arising with refusal or inability to eat meals. It is
12 submitted that it is plain that nothing in Aberlour's
13 rules authorised, proposed or condoned punishment for
14 bed-wetting or daytime incontinence or for declining to
15 eat food on grounds of taste or lack of appetite. And
16 it is readily accepted that punishment of young people
17 in such circumstances would have been entirely
18 inappropriate. Aberlour reiterates its sincere apology
19 to any child who experienced such punishment in any of
20 the organisation's establishments.

21 Equally, nothing in the rules authorises, proposes
22 or condones punishment for speaking out about harsh
23 behaviour at the hands of others, be they adults or
24 other children. Moreover, nothing in the rules
25 authorises or proposes punishment such as locking

1 children in cupboards or force-feeding or imposing
2 excessive chores. Again, such conduct would be entirely
3 against the value system which the Aberlour rules
4 expected all staff to adhere to. Aberlour offers its
5 sincere apologies to any person who experienced such
6 harsh treatment while in its care.

7 Moving on to the issue of absconding. The inquiry
8 has heard evidence about absconding particularly from
9 Aberlour Orphanage and also the importance of
10 ascertaining whether a child is running from or to
11 something. As is set out in greater detail at
12 paragraph 225 of SallyAnn Kelly's organisational witness
13 statement, it's perhaps better understood in the present
14 day that all behaviour by children and young people is
15 a form of communication. It is regrettable that it does
16 not appear to have been understood at the time that
17 absconding was a form of communication and it is plain
18 that punishment in response was not apposite, despite
19 the terms and content of the Aberlour rules.

20 Turning to corporal punishment. In the orphanage
21 years, Aberlour did have a policy on corporal
22 punishment, that being the Aberlour rules. Those rules
23 were in place before the arrival in Aberlour's care of
24 any of the applicants whose evidence is available to the
25 inquiry. That policy made it plain that it was the

1 intention of Aberlour that all staff would operate and
2 conduct themselves in accordance with the policy. It
3 was Aberlour's expectation that children would know what
4 the policy was in order for adults to be held
5 accountable for it.

6 Corporal punishment imposed, other than in
7 accordance with the policy -- and it is clear that that
8 occurred -- does not demonstrate a lack of a system,
9 rather it would point it to failure by staff to adhere
10 to the system that was in place. Such a failure would
11 never have been acceptable to Aberlour and it is
12 something that Aberlour regrets and apologises for.

13 To any child who did experience corporal punishment
14 in the care of Aberlour, which was inconsistent with the
15 policy system which it had created and sought to
16 enforce, whether excessive or inappropriate --

17 LADY SMITH: The way you put it, Mr Love, that it was
18 Aberlour's intention that children would know what the
19 corporal punishment policy was and for adults to be held
20 accountable for this doesn't really sound like the way
21 a child's mind would work, does it? If I'm seven,
22 I probably am not aware, if I'm 7 years old, that
23 there's any policy on corporal punishment at all. Even
24 if I'm vaguely aware of there being some rules, I'm not
25 going to think about it in terms of being able to hold

1 adults to account if the rules are broken by them, am I?

2 MR LOVE: No, that is correct, my Lady, and your Ladyship
3 did hear the evidence of SallyAnn Kelly on that very
4 point. I think it was a question your Ladyship asked of
5 Ms Kelly --

6 LADY SMITH: I did and I think she accepted --

7 MR LOVE: -- and she did accept it entirely and she
8 qualified her observation, if my recollection is
9 correct, by indicating that it was more directed towards
10 the older children and certainly not the younger
11 children because it would be entirely inappropriate to
12 expect them to engage in any system of punishment.

13 LADY SMITH: Even with the older children, there has to be
14 a really sound and secure means by which they know they
15 can confidentially communicate their disquiet if they
16 think they're not getting fair treatment according to
17 whatever the rules of the place are.

18 MR LOVE: Absolutely, my Lady.

19 LADY SMITH: Thank you.

20 MR LOVE: Turning to the issue of sexual abuse, it has to be
21 expressed again in the most emphatic terms that sexual
22 abuse of any sort has at all times been both
23 diametrically at odds with the aims, ethos and purposes
24 of Aberlour, and entirely unacceptable to the
25 organisation at all stages and in all manifestations of

1 its existence.

2 Aberlour proffers its deepest apologies to any child
3 who experienced any form of sexual abuse while under its
4 care.

5 I'm going to deal specifically with the
6 circumstances surrounding Mr Lee at Aberlour Orphanage.
7 Your Ladyship and the inquiry has heard evidence about
8 the late Mr Lee and his sexual abuse of a number of boys
9 at Aberlour Orphanage in the period prior to his
10 dismissal from Aberlour's employment and his conviction
11 in 1963. It is clear from the evidence before the
12 inquiry that the fact of Mr Lee's conviction and
13 imprisonment was not relayed to his victims, nor is
14 there any indication given in the contemporaneous
15 records available to the inquiry of details of Mr Lee's
16 conviction and imprisonment being relayed to parents of
17 victims.

18 Due to the absence of records, it is not possible to
19 explain the reasoning behind the complete failure to
20 relay information of this type at this time with any
21 degree of certainty. It is readily accepted that it may
22 have given comfort, or greater peace even, to victims to
23 have been aware at the time of these events of the
24 conviction and imprisonment of their abuser. This also
25 applies to the victims of Mr Lee from whom the inquiry

1 has not received statements or heard evidence.

2 Aberlour offers its heartfelt apologies to all of
3 those boys who suffered abuse at the hands of Mr Lee.
4 In addition to that, the sincere apologies of Aberlour
5 are offered for the lack of communication following the
6 conviction of Mr Lee, for the missed opportunity to
7 offer the fullest support, reassurance and comfort to
8 those in greatest need of this, and for any additional
9 distress or trauma this may have caused to those who had
10 already suffered abuse and to their families.

11 In the present care of Aberlour, in the event of
12 there being a prosecution resulting in conviction and
13 sentencing of an abuser, close consideration would be
14 given to the appropriate method to share this
15 information with the victim in a supportive and
16 supported environment.

17 In present practice, Aberlour employees speak openly
18 to children about behaviours and what is expected from
19 both them and adults. Aberlour staff speak openly with
20 young people about safety and keeping each other safe.
21 They also let children know that they can share concerns
22 with any member of staff or with any person they choose
23 to speak to. The inquiry has heard evidence that
24 Aberlour funds independent advocacy through Who Cares?,
25 and moreover, that this service is well publicised

1 in that Sycamore Cluster establishments have posters on
2 display giving contact details.

3 Moving on to the position with records. Aberlour's
4 response to the inquiry is necessarily based upon
5 a review of the evidence available from the statement or
6 statement and evidence of each of the various applicants
7 as well as a review of its own file for the applicant
8 and any management committee meeting minutes addressing
9 matters arising.

10 Social work and medical records might provide an
11 additional source of information other than a review in
12 isolation of the files and minutes held by Aberlour.
13 That has become increasingly obvious from the evidence
14 that has been taken from applicants. In certain
15 circumstances it appears to have been proposed that
16 absence of documentary evidence is evidence of the
17 absence of any contemporary record. Just with the
18 passage of time and the fact that records have not been
19 capable of being found, I would submit to your Ladyship
20 that that wouldn't be justified or reasonable and
21 perhaps runs the risk of inviting speculation.

22 In the case of Mr Lee, for example, it may be that
23 there are in fact social work or medical records that
24 exist and might provide further pertinent detail. The
25 enquiries that have been carried out by Aberlour have

1 been unable to find any documentation in their own
2 archives relating to the incident and the incidents and
3 what arose. But the fact that they have not been traced
4 does not mean they didn't exist at one point, but it
5 certainly raises a question as to whether or not there
6 may be further documents that could educate about the
7 situation that prevailed at the time.

8 The inquiry has heard some evidence about applicants
9 experiencing either delay in retrieving or recovering
10 records from Aberlour or receipt of incomplete records
11 and for that Aberlour apologises.

12 Aberlour's position is that any former resident is
13 entirely welcome to seek to recover the records which
14 Aberlour holds which relate to that individual. Indeed,
15 residents have a statutory right to recover their
16 records. There is no fee for this. Applicants can
17 either contact the quality and safeguarding manager at
18 Aberlour by telephone or via the website or can begin
19 the process online without having to speak to anyone at
20 Aberlour, and that's by means of completing a form again
21 on Aberlour's website.

22 Aberlour will be glad to assist any former resident
23 with that process and moreover any resident who
24 otherwise wishes to discuss their experiences in
25 Aberlour's care with Aberlour itself is most welcome to

1 make contact with the quality and safeguarding manager.

2 Moving on to current policies and procedures,
3 Aberlour has developed a suite of policies, all
4 accessible via their website, and those contribute to
5 the protection and welfare of children by promoting high
6 standards and ensuring that staff are held accountable
7 by managers and by each other.

8 I don't intend to take up time looking at the nature
9 and extent of those policies, but links are all
10 available on the Aberlour website, and your Ladyship
11 will find them within the full closing statement itself.

12 Aberlour's full closing statement makes reference to
13 Aberlour's current complaints policy and the fact that
14 the organisation takes all complaints seriously,
15 irrespective of their source. Again, I don't intend to
16 take up time today by looking at the nature and extent
17 of those policies and procedures in relation to
18 complaints.

19 Turning to recruitment of staff. Aberlour's
20 approach to recruitment of staff in the service years to
21 the present day and in particular the developments
22 in relation to the checks carried out in connection with
23 the suitability of applicants is set out in detail at
24 paragraph 115 and following in SallyAnn Kelly's
25 organisational witness statement. The inquiry heard

1 evidence about Aberlour's recruitment and continued
2 employment of Mr Adrian Snowball and the lack of honest
3 disclosure by him of a previous pertinent criminal
4 conviction.

5 The systems in place did not successfully identify
6 the existence of that conviction and that's more fully
7 addressed in Aberlour's full closing statement and
8 I don't intend to take up time with it today unless
9 your Ladyship would wish me to.

10 LADY SMITH: We have it. We looked at it in detail,
11 observations can be made about questions that weren't
12 asked on the back of what he did or didn't put in the
13 form, and also about the very real risk that somebody
14 like him will do this --

15 MR LOVE: Absolutely.

16 LADY SMITH: -- and not volunteer what he should be
17 volunteering.

18 MR LOVE: Absolutely.

19 In relation to training and qualifications, the
20 inquiry has heard evidence about that. It's important
21 to consider when looking at the historical position to
22 look at the evidence about lack of training in the past
23 in its historical context -- and by that I mean looking
24 at the extent to which training was available from
25 external sources. Much evidence was heard about that.

1 In the present, Aberlour is a learning organisation,
2 it takes its responsibilities for the training of staff
3 and assisting them in obtaining qualifications
4 seriously. A learning approach is adopted to any
5 significant events prompting open, transparent and
6 candid reflection on what might have been done
7 differently and again your Ladyship heard evidence from
8 SallyAnn Kelly about a particular event that raised
9 transparent and candid discussion and reflection.

10 The inquiry has heard evidence about a plan to run
11 a six-month pilot scheme where Aberlour will endeavour
12 to cease to use physical interventions with children at
13 all. Children will only be touched by staff in
14 a calming and sensitive way, offering warmth,
15 reassurance and comfort, with a view to helping
16 self-regulation. In relation to this pilot scheme,
17 input is being sought from both children and staff and
18 that's of key importance.

19 Dealing with two final matters. Firstly,
20 Professor Abrams' draft report. For reasons identified
21 by others, I intend to make no submission at all about
22 the content of Professor Abrams' report at this stage.
23 I may in due course, and if appropriate, apply for
24 questions to be asked of Professor Abrams through
25 your Ladyship and seek to --

1 LADY SMITH: Absolutely, as was made clear, it was presented
2 at this stage in draft form and it wasn't being
3 suggested that that was the last word that she had to
4 say.

5 MR LOVE: And in terms of the observation that Mr Scott made
6 this morning about a reference to a question being put
7 to one particular applicant, BHI, all I would say about
8 that is that the question Aberlour asked to have put to
9 BHI was made clear by SallyAnn Kelly in her evidence and
10 that's at Day 119, 30 January 2019, at page 17 and
11 following. The question as put was not a question that
12 Aberlour asked and Aberlour agree that it is very
13 important to be careful with words.

14 In closing, Aberlour recognises the value and
15 importance of the work of the inquiry and undertakes to
16 continue to give the fullest assistance that it can to
17 the work.

18 That's the closing submission for Aberlour, my Lady.

19 Housekeeping

20 LADY SMITH: Thank you very much.

21 There are one or two things I want to say about
22 where we're going for the rest of this year. But before
23 I do that, can I check whether there are any other
24 issues anybody wants to raise at this point. No?

25 Well, firstly, just under reference to the case

1 study that is now coming rapidly to a close, that's the
2 case study into the provision of residential care for
3 children by Quarriers, Aberlour and Barnardo's. As with
4 the two previous case studies now that it is complete,
5 I will be taking time to consider my findings in fact in
6 relation to these three institutions and they will be
7 published in documentary form after that.

8 That takes me to the findings in relation to the
9 Sisters of Nazareth case study and I know that many are
10 anxiously waiting to see a document setting those out.
11 I'm pleased to say that it is nearly there in the sense
12 that the findings are going through a publication process
13 at the moment and the final booklet is very close to
14 being completed. I hope to be able to announce
15 a publication date very soon, but I'm sure you all
16 appreciate that the technicalities of the publication
17 process and some of the electronic procedures that have
18 to be gone through, whether it is hyperlinking or other
19 mechanisms, that does take a little time. I know you
20 want to know, if I can put it that way, and I'm doing
21 very, very best to accelerate that date as fast as
22 I can.

23 Let me turn now to the hearings for the remainder of
24 2019. The first date to note is 25 March, just that one
25 date. We'll be taking the evidence of another witness

1 whose evidence relates to the child migrant case study
2 by video link from Australia. Because of the relevant
3 time differences, we'll be sitting outwith normal
4 hearing hours, this time in the evening. It will be --
5 we're not absolutely sure yet, but around 8.30 pm,
6 probably something like that, but if you keep an eye on
7 the website, you will get a confirmation of the timing
8 of that hearing closer to the date. That's 25 March.

9 An announcement will be going out very soon
10 in relation to applications that will need to be made
11 for anyone who wants leave to appear for that evidence.

12 Let me take you then to April and phase 1, part C.
13 In the week of 2 April, and probably running into the
14 week after that, we're going to hear research evidence
15 from Professor Kendrick, who is a professor of
16 social work and residential childcare, who will speak
17 about some aspects of his work on the development of
18 services for children in care. Also Professor Levitt,
19 to whom we've already referred today, will be giving
20 evidence about part 2 of his report on inspection
21 systems. And Professor Norrie, who will be giving
22 evidence on part 3 of his report about the relevant
23 legislative and regulatory framework. And
24 Professor Abrams again who's been referred to today, who
25 will be giving evidence about the effectiveness of

1 inspection systems following her investigation and
2 analysis.

3 If I can then take you a little further forward in
4 the year, and we'll get to phase 4. Phase 4 is going to
5 involve a series of separate case studies in which we'll
6 examine the provision of residential care by a number of
7 male religious orders. We'll move to this phase of
8 evidence in early June.

9 There will be three consecutive case studies. The
10 first is going to focus on provision at St Ninian's in
11 Falkland, which was run by the Christian Brothers. That
12 will start on 4 June and we expect it to take until
13 early July.

14 The second case study that will follow that one will
15 examine the provision of care for residential care at
16 the Carlekemp and Fort Augustus Abbey schools. These
17 are two boarding schools that were run by the
18 Benedictines, and that case study we expect to run until
19 the week of 23 July.

20 We will then have a break over the summer period and
21 resume hearings on 10 September and then we'll turn to
22 the third case study in this phase. It's going to
23 examine the provision afforded by the Marist Brothers at
24 St Columba's in Largs and St Joseph's in Dumfries, and
25 we expect that to run until late September/early

1 October, there or thereabouts.

2 Then, after a pause towards the end of the year,
3 we'll move to phase 5, and that will be our case study
4 into the child migration programmes. Of course, we have
5 heard some individual witnesses in relation to that
6 phase already, but there's more evidence to come, and
7 from that time, that's the end of the year, we will be
8 hearing directly from child migrants who come here to
9 give evidence and also we expect to be arranging more
10 video link evidence for that.

11 We'll provide further details of the hearings
12 schedule in advance of all the hearings. Watch the
13 website and if you're in any doubt get in touch with the
14 inquiry team.

15 So far as future case studies are concerned, we
16 continue constantly to review our programmes for
17 hearings and we'll be announcing future case studies
18 later this year.

19 I should perhaps at this stage emphasise that due to
20 the volume of evidence we're receiving, it won't be
21 possible to hold a case study into every single
22 institution but all the evidence we receive will be
23 carefully considered, analysed by us and appropriately
24 taken into account to inform the final report and
25 findings.

1 Can I encourage anyone who has evidence that's
2 relevant to our terms of reference to contact the
3 inquiry's Witness Support team. Everybody matters and
4 we want to hear from everyone who has relevant evidence
5 to offer.

6 Then if I can turn to a final matter, and that's
7 that part of our investigation and hearings that I would
8 refer to as the history of relevant events in the period
9 2002 to 2014. During the first part of phase 1,
10 I indicated I was interested in hearing more about
11 relevant events in the period between the lodging of the
12 petition by Chris Daly in 2002 in which he called for
13 a public inquiry and the announcement of such an inquiry
14 in late 2014.

15 At this stage I can say that there have been
16 investigations by the inquiry into this and they're
17 continuing. Those investigations include gathering
18 evidence from relevant officials and relevant government
19 ministers. Whilst the presentation about this period
20 won't form part of this year's programme of public
21 hearings, my current intention is to include evidence
22 about it in inquiry hearings during 2020 so as to take
23 account of any developments that have occurred since the
24 setting-up of the inquiry, such as, for example, the
25 outcome of Scottish Government's stated intention to

1 establish a redress scheme for those who were abused
2 when in care as children.

3 That's all I have to say at the moment. It remains
4 only for me to thank all of you who have been here with
5 leave to appear to contribute to this lengthy case
6 study, to thank counsel to the inquiry who have worked
7 so hard on it, the inquiry team behind the scenes who
8 have also been working extremely hard, and the faces
9 I see in the public seats who have been here so often
10 and so interested in the very important evidence we've
11 been hearing. Thank you for coming along to do that.
12 I'll now rise.

13 (2.55 pm)

14 (The inquiry adjourned until Monday, 25 March 2019
15 at a time to be determined)

16
17
18
19
20

21 Closing submissions by MR GALE1

22 (continued)

23 Closing submissions by MR SCOTT16

24 Closing submissions by MS LAWRIE42

25 Closing submissions by45

1 MS van der WESTHUIZEN

2

3 Closing submissions by MS O'NEILL47

4

5 Closing submissions by MS DOWDALLS55

6

7 Closing submissions by MR JACKSON93

8

9 Closing submissions by MR LOVE113

10

11 Housekeeping136

12

13

14

15

16

17

18

19

20

21

22

23

24

25

