Scottish Child Abuse Inquiry

Witness Statement of

KTN [redacted]

Support person present: No

1. My name is KTN [redacted]. My date of birth is [redacted] 1954. My contact details are known to the Inquiry.

Background

2. I would like to put a few things in context about my employment, and my meeting with the Scottish Child Abuse Inquiry, which is both sad and salutary for me. I appreciate that for people, when you look back at the residential care sector, it must appear a grim place, but there were those of us who made it our work, our careers, to try and make it better. I had the fortune of being born into a very good home. My parents started fostering when I was nine years old. So, I kind of know the childcare system from the 1960's.

3. When I was eleven years old, my parents decided that they would try and adopt a child. I went with my parents to a children's home in the west end of Glasgow. Although it was 59 years ago, I can remember it quite vividly. This was one of the homes that was later referred to as a 'baby farm', which is quite a shocking term, but it is the way things were. There was an age progression where children were moved from place to place.

4. When we went into the children's home there was a person who met my parents and said, "Well, just pick one." We were all shocked by that, it was not what my parents expected. My mother asked about one little baby. The Matron said, "You don't want that one, it's retarded." I think that provoked my parents and that child is my younger

brother, who is now 59 years of age. It is still quite emotional to think about that, but my point is that I can remember the system being "burst."

5. I was brought up in what I think would be termed a Christian-Socialist environment, where there was a very strong public service ethos, and a desire for change. I was involved in youth work. When I was eighteen years old, I was deciding what to do and I ended up doing social studies, with a view to doing some kind of youth work, but I had no idea what.

Qualifications/Training

6. I have a B.A. in social studies. I have a certificate of qualification in social work. I have a master's degree in business administration, and I have a post-graduate qualification in social work education. I gained all of these qualifications prior to my employment at Kibble school.

7. After doing my social studies degree I spent eighteen months as a hospital porter, which was not the normal employment trajectory, but I wanted to get life experience. I felt I had been a bit sheltered. Being a hospital porter certainly broke that because of everything I had to do at that time.

8. I then was asked if I would go into full-time youth work. A friend had said that there was a new place opening where they were going to try to change things. In late 1976 I was interviewed for a job in what had just become Strathclyde Regional Council. I want to try to give context for the dates at which I was working because I think that one of the challenges that I think bodies like the Inquiry face is the idea of presentism, where you view the past through the lens of the present. I want to give you the context of what the world seemed to me to be like then.

9. In 1976 Strathclyde Region had just come into being. It was full of a reforming kind of zeal. There were huge ambitions for change, and as I then discovered, there were people who wanted to change the childcare sector, the residential care sector, and the

fostering and adoption sector. This clearly appealed to me, with what had happened when I was younger, and the way that I had been brought up. I was interviewed in Autumn 1976 by three people who were leading the charge in the reform of social work services. The three people who interviewed me were Bob Nummey who I think was the Principal Officer or Assistant Director of social work. The other two were Sadie Fitzpatrick and Liz Jack. Bob and Sadie are dead now, and I think Liz may have passed on too.

10. That interview was full of promise and wanting to change the system. People acknowledged that the system was broken. They were going to change children's homes, fostering, and adoption. That lit a fire under me. I decided against going into administration, I wanted to stay in residential care. However, due to cutbacks, I never started until April 1977. I started in a place called Gilshochill Assessment Centre in Maryhill, Glasgow.

11. Gilshochill looked like something out of the Adam's Family. It was in an old industrial school. It had also been a school for the deaf, and for problem girls. It did look like the haunted house on the hill. They were going to operate it as an off-shoot from Larchgrove, which was the infamous remand centre of the day. A remand centre at that time could be dealing with children as young as eight years old. What the senior staff wanted to do was to create a safer kind of place for those that they considered the more vulnerable children who were coming into Larchgrove. That was where I started.

12. When I started in Gilshochill I did get one week of training. They took you round different places to see how they ran. I got taken to a place in Paisley called Kibble residential school. I was 23 years old at that time and I was terrified. Kibble was definitely still running as an Approved School at that time.

13. The Social Work (Scotland) Act 1968 did do away with Approved Schools. All the names changed. They had different lists of categories of schools at the Scottish Office, such as the List D schools, and the List G schools. The List D schools were for the

delinquent, and the List G schools were for the maladjusted. These types of school then developed their own sort of stigma.

14. After two years at Gilshochill, I was given a full-time secondment with a contract to come back and work for the social work department, so I could do my social work qualification. I had to continue to work for the social work department for two years. I think I was the only person who went back into residential work because that was always seen as a way into social work, never a destination in itself. People were brought in with no training. The select few had social work training but the vast majority were untrained, so when I came back, I was in a promoted position at the age of 25 or 26. It was a kind of meteoric rise for a young person.

15. In 1981, after two years, they decided to close Gilshochill because of budget cuts. Under the Thatcher government local authorities were being really squeezed and hammered. Although they were closing Gilshochill, the movement to reform children's homes had really taken hold. There was a big surge in trying to reform children's homes in Strathclyde. There was also a big thing called intermediate treatment which was meant to be diversionary. There was a huge effort to get the vast numbers of children in institutional care down.

16. I spent more than another year working in a children's home. My wife and I did voluntary work, during our holidays, in India and Bangladesh. My wife also had a charitable business providing goods for the third world. I did not like the children's home I was working in. It was a different world from what I had been used to. Those children's homes, although they were launched in a fanfare of hope and expectation, were not well thought out or planned. I think most of those homes had gone by the end of the 1980's.

17. By 1984 or 1985, Liz Jack asked if I would come back into the residential care sector and go into Larchgrove Remand Centre. I lived in the east end of Glasgow at the time. I started in Larchgrove in 1984 or 1985. At that time, places like Larchgrove operated more like junior prisons. This was seventeen years after the Social Work (Scotland)

Act 1968, which meant that places like Larchgrove were not meant to exist. My job title was Senior house parent. It was one step up from my previous role.

18. Places like Larchgrove were hard, dark places. They were uncompromising. Children were in big dormitories and wore uniforms. Glasgow had built a secure unit at Larchgrove. They started that in 1983. I was told that I would take a senior role in the secure unit. Although it was modern, it remained unopened. Although it had cells, they were single rooms. It could have been made decent, and eventually it was.

19. In 1985 I moved to Cardross Park Assessment Centre, as SNR [redacted]. I had been asked if I would go there and help because all those places were in chaos. It is hard to describe, but getting through each day was a challenge. The whole care and control issue was completely confused. There was a huge amount of damage being done in places, with kids out of control. People really struggled to get any sense of order. I was there for two years, then I was asked to go to Newfield Assessment Centre, as SNR SNR [redacted], for six months because there had been financial irregularities.

20. Again, Newfield Assessment Centre was a place in chaos. It had been launched in 1985, and was supposed to show the rest of the world how residential care should be done. They brought in people from field social work, which caused huge animosity amongst people who worked in residential care. Things escalated and there were a number of riots by the children in Newfield, with rooftop protests. It was the residue of the time of prison rooftop protests. They were a way to get attention. It freaked everyone out because it was so visible.

21. After the administrative issues had been dealt with at Newfield, I went back to Cardross. In 1989, Liz Jack contacted me again. By that time, she was then principal officer in Strathclyde region. She asked if I would go to Kerelaw Residential School. She said that there were all sorts of problems at Kerelaw. There had been a significant disturbance there in late 1988. SNR [redacted] there had gone off sick. I was promoted to SNR [redacted]. I had been brought up in the local authority structure, so I did not have experience of residential schools.

22. There were all sorts of chaotic administration systems at Kerelaw. The resources to do anything were threadbare. The thing that astonished me when I arrived at Kerelaw in 1989 was that the ratio of staff to children was significantly less than in the children's home where I had previously worked. I cannot remember what that ratio was, but it seemed incredible when Kerelaw was taking the most difficult kids from across the country. Any request to improve staffing was ignored.

23. There was a secure unit at Kerelaw, beside the open school. That had its own issues. The was a strong influence from the English authorities on the running of the secure unit. There was a big secure residential place in England called Aycliffe, which for a while was seen as the model for residential care. The Home Office also ran two specialist units in England, and SNR of Kerelaw had been brought up from one of them. There were all sorts of paradoxes in staff training.

24. In spite of all this, people were trying. The Keyworker system had been adopted and there was an attempt to have a relationship-based approach to residential care. Throughout this, Kerelaw was being used as a dumping ground, and I hate to use that term. Strathclyde region used the term, "difficult to place" children. These children could not be accommodated in any of the alternative community resources, they could not be maintained in any of the other residential facilities.

Kibble School, Paisley 1993 to 2017

25. In 1993, I SNR of Kibble Secure Residential School. Kibble school was almost identical to Kerelaw, but that was no accident because all the residential schools were staffed pretty much the same way as Kerelaw. It was retrospective learning for me because I discovered that in the List D schools, those in charge still wanted to be called governors, but that was dying out, and they were being referred to as headmasters.

26. The headmasters saw themselves as a kind of breed apart. They saw the system as separate from them. That attitude had been fed by the management arrangements

because The Scottish Office still had local government managing all the services for children, but there was an independent charitable sector who managed some institutions and were funded by The Scottish Office up until 1986, so it was The Scottish Office who were effectively running those places too. There were about 25 to 30 such places, so the number of kids in care in Scotland was outrageous.

27. I was seen as a young liberal when [redacted] at Kibble. I was just in my late thirties. I suppose I saw the others [redacted] as old dinosaurs, but they kept the system going.

28. In 1986, The Scottish Office shifted the funding to local government and set up a thing called the Single User Agreement, which was basically the way that Strathclyde Council financed the residential schools in the independent sector, until 1996. Strathclyde Regional Council and other council areas were trying to manage all the independent schools that were in their geographical areas through the Single User Agreement, although for political reasons there had been a small group of schools who were given direct funding by The Scottish Office. Those were the schools that had previously been in the category of dealing with maladjusted children, rather than delinquent children. As a history lesson, it sounds mad and at the time it felt mad.

29. The Scottish Office were very "hands-off" in their approach. Strathclyde Regional Council came in with a "hands-on" approach, because they were controlling the purse. The Strathclyde Regional Council system was chaos. The things that were in their own remit were not good. Any sense of leadership, purpose, or planning for things never existed.

Experiences at Kibble

My role and recruitment at Kibble

30. I applied for the post of SNR [redacted] at Kibble. The job was advertised externally from Kibble. My predecessor had vanished in a cloud, so the vacancy was the subject of general discussion.

31. I was given psychometric testing as part of the recruitment process. There used to be a thing called the List D psychological services. They were very high calibre, they were the gurus of the sector. They had a controlling interest across all the List D schools. I do not think they had a formal line of reporting in to the social work services group in the Scottish Office.

32. The psychometric test was administered out of Edinburgh. The [redacted] stream, up until 1996, was mainly Edinburgh based in terms of practice oversight, until it switched to local government.

33. It was one of the List D psychological services team that did the psychometric testing. Then I was interviewed by a representative from Strathclyde Regional Council, the chair of the charitable trust trustees, the head of education from Renfrewshire who was one of the trustees, and someone else.

34. I was appointed SNR [redacted] at Kibble, much to the consternation of many because I did not have any teaching qualifications. I was a qualified social worker.

The role of SNR [redacted] *at Kibble*

35. When I went in as SNR [redacted] of Kibble in 1993 I was inheriting the status quo, from the system, not just from Kibble. Kibble was very difficult then. There had been maladministration of financial things by [redacted] SNR [redacted]. As far as I know there were no abuse allegations, but there was financial maladministration. I had dealt with that kind of thing twice before. I think that was why I was given the job, because I was the first social worker in the United Kingdom to have a master's degree in business administration. That and my background in residential care meant that I was the only one with any kind of meaningful financial qualification.

36. I came to Kibble with the view that I would be reforming it and trying to bring a more humane approach, trying to get the balance of care and control right. Within a year of

my arrival at Kibble, it was signalled that Strathclyde Region would be ending due to the changes to local authority structure. That meant that everything was up in the air.

37. In 1996 Kibble became a board led organisation. There were four senior staff on the board. The chair of the board's position was that we were full members of the board because we were [redacted] staff. We [redacted] the place, so we should be part of the board. That was a very unusual structure. In most of the other residential schools the trustees remained separate from the senior staff. We had to re-invent the organisation.

38. We became quite reforming. We wanted to change the way that residential care for young people in serious trouble was done. We had lofty ambitions, and that meant changing the model, changing the funding arrangements, changing the governance, and fundamentally changing everything about the way that we did the work. [redacted] had to operate Kibble as a social business.

39. We decided that we were really going to try to get to grips with understanding what we were doing, and to know why we were doing it, to better inform ourselves. We set ourselves the mantra, "Do we do what we say we do". We were trying to modernise an old institution. We started to look across the United Kingdom for research, and then started to look internationally.

Layout and Structure of Kibble

40. When I first went in to Kibble, it was chaos. There was a senior staff on-call rota. There were four senior staff, so they were on-call one night in four. For the first year or so, we seemed to be out in the middle of the night with disturbances. Kibble is right beside the M8 motorway, opposite Glasgow airport. We had a few incursions into the airport, including one with a group of kids running across the runway. These were high profile things.

41. Administratively, they were still using typewriters at Kibble, no-one was using a computer. I said that would be changing but people were resistant to change. What characterised my first few years were internal battles and external battles. I was seen

as a young smart-ass, a know-it-all. I was new and had never been in the List D sector. I was told to my face, "This is man's work son."

42. There were trustees for Kibble. All the independent schools retained trustees. For example, the Kibble trustees met once-a-quarter and were told the story of what was going on, because the trustees owned the assets of the school but had no control. They could have had control, but everyone chose not to because all the headmasters wanted control. The Boards of trustees were not what you would call a functional charitable board. Effectively, what you had was all these quasi-independent schools who never operated as independent.

43. With the restructuring of local government and the end of the regional councils it became clear that because there would be no big regional authority, the future of Kibble may be in doubt. Certainly, the funding was in doubt. Our board of trustees started trying to galvanize things. They brought on a retired solicitor to take control. They set up an interim company, limited by guarantee, which would operate as a charity, and get charitable status.

44. Between 1993 and 1996 the Single User Agreement continued. That meant we had to follow the instructions of Strathclyde Regional Council. We had no local discretion. I think that would be illegal now, in the administrative sense, having charities managed that way, but that is the way that it was done.

45. In 1997 with the Labour government coming in, there was a new thing called the third way. This meant that Kibble was not run as a local or central government institution, or as a private institution. The third way meant that it was run as a mission-driven business. The social purpose was as important as financial solvency. The job of these companies would be to juggle that balance. That was how we set up. On the first of April 1996, the new Kibble came into being and my title [redacted] SNR, and I [redacted] SNR [redacted].

Financing of Kibble

46. Previously the funding model was that the residential schools were paid quarterly in advance, but all that went with the change from regional authorities to local authorities. You were allowed to hold a maximum of £10,000 in reserves. Strathclyde Regional Council had asked us to carry out a unit refurbishment in the winter of 1995/6 but then they didn't pay us for it. That meant we opened with £10,000 in the bank but a deficit of owing contractors £45,000. You cannot believe the insanity of it. Then all the local authorities agreed that they would pay us for the kids that we had in.

47. Before local authority government, when places like Kibble were being funded by regional government, these placements were free. We got a block grant every three months, but no-one paid per placement. After 1996 because local authorities had to pay per-capita per placement, demand for placements initially fell. We had started to adjust to placement depending on need. That meant local authorities did not want to pay. Sometimes that meant that local authorities were placing children in inappropriate placements. We felt that would add to their trauma, but the local authorities just thought that we wanted the youngsters to be placed at Kibble for financial gain.

48. All of these things were happening at the same time. Every week, we were doing a daily update on our cash position, because we had no cash. We were completely independent, there was no safety net. But the senior staff had made a commitment that we would never take a young person just because we had an empty placement. That was a pact amongst ourselves, it was not written down in a document.

49. We started to bring in some money from charitable trusts to give us a level of independent funding that we were never getting from the statutory basis. We were trying to be educated and informed about residential care.

50. We then got some European money to go into a research partnership which got going in 1998. We did a transnational study of children in Finland, Spain, Ireland, and Scotland to see why children were ending up in the kinds of institutions that all of these countries had. We wanted to find out what had happened.

51. By 1998, local authorities were now only placing children with us in-extremis. We were only getting the children they could not handle. We had begun to adjust staffing levels based on the needs of the children. We were seeing a distinct pattern of youngsters coming to us over these two years, which really was a distillation of what had been happening over the previous years but had been narrowed down a bit because local government was then much smaller and had to deal with things in its own kinds of areas.

Policy at Kibble

52. When I started as [redacted] at Kibble, there was no definition of its purpose, other than it was part of that group of residential schools whose function was dealing with children at the end of the line. No-one was arguing with that. There was an understanding of purpose, as in what they were to do, but I felt there was no understanding of why we were to do what we were to do.

53. When [redacted], then Kibble became truly independent. Then we felt we really needed to deliver on understanding as well as doing, and to develop mission statements and such like. As things developed over the years, I felt that did start to solidify.

54. It might not have seemed it at the time, but we were trying to haul a system that was archaic into the twentieth century, just as everyone was leaving the twentieth century.

55. Because we started to understand who we were working with, we started to develop services accordingly. Remember that places like Kibble were generic. I am not saying that there was no specialisation, there had been attempts to specialise, but some had gone very badly wrong.

56. One of those schools where things had gone badly wrong was Loaningdale, in Biggar. One of the young people there had murdered a local person. Loaningdale had been

set up to become one of the places that was modernising things, but it closed down within a couple of years because of the impact of the murder upon the local community.

57. My involvement in the making and implementation of policy at Kibble was full-on. It was a board matter. The board did not just have an administrative function, the board was involved with the practice within the organisation. There was a psychologist on the board, there was someone who had been very senior in the children's panels in Scotland. The board, and the trustees before them, always had a strong grouping. We processed all the stuff through the senior team. It was quite a traditional hierarchical system.

58. [redacted] would have been on any new policy, but it was not [redacted] decision, it would be the decision of the board. The person who became the chair of the new company board was an old G.P. Dr Munroe. His father before him had been chair of the trustees. It was a dynasty. Dr Munroe was a kindly, progressive man. He was very clever. By the time I got to Kibble he was in his mid-seventies or probably older. He felt that if there was to be a new board there should be a new chair of the board. Jimmy Jack was one of the local solicitors who was a part-time sheriff, and he took on the position of chair.

59. The degree of accountability within the organisation was extraordinary. There was a full trail of policy and all those kinds of things. The board wanted involved, because there was a desire for Kibble to be a safe place for youngsters. People knew the history of what was going on elsewhere. The non-executive directors were not an abstract group of people, they wanted to make sure that what was being done was good, right, and forward-looking. Remember that these people went from being trustees who met once-a-quarter to monthly meetings where they had absolute responsibility. The buck stopped with them. They were committing to a place in Paisley, surrounded on three sides by houses, which was going to take the most difficult youngsters in the country.

60. All the board members names were on the line. They wanted to make sure that what we were doing was right. I am sure the records will still exist. You could look at board meetings from the 1990's that were hours long. The detail of the board reports was

extraordinary. We had incident reporting through the board as well, so that the board could see trends, in absconders for example. We were modernising, we had shifted onto really advanced information technology capabilities. We shifted things out of the Dickensian into a really modern practice.

61. We were being part of things. I became a [redacted] of Children in Scotland because I felt that Kibble needed to be seen as a children's establishment, not as kind of linked to the prison service. In order to take that [redacted] position, I had to get approval from the Kibble board, so they supported me, and other senior staff, in being active and outward looking.

62. In the couple of years between 1996 and 1998 we really were all hands to the pump. We were trying to reshape the organisation. We were doing this while we were keeping everything going, so I am not going to suggest this was a fresh start, it was an evolution of what we tried to make a different approach. We knew it anecdotally, but we only began to realise how significant the challenges were that faced the young people who came to us. That was completely accelerated by the change away from the regional councils to the local councils. You went from eight councils to thirty-two. Each council was going to try to develop its own thing.

63. A few local authorities said that they were never going to use places like Kibble again, which seemed to me naïve because I thought they would always need such places. As long as the councils regarded such places as a last stop service, that was going to influence how they dealt with children and young people.

64. What became clear to us was about the statistic of young people having multiple placement breakdowns. To me, there is a profoundly negative impact on young people who go through multiple placement breakdowns, and I think that there may be some research on this. I think that some of the young people who were causing the most disruption in residential establishments were not the youngsters who had committed the most delinquent acts or the most serious crimes, they were the young people who were the most profoundly disturbed by placement breakdown, because they were the young people with nothing to lose. Their behaviour was completely uninhibited.

65. If the average age of initial contact with the social work department was seven years old, and they were coming to us at the age of eleven to fourteen years old, then they had had multiple placements by that time. Many of them would have been bumped about between family members, then there would often have been failed fostering placements, then they would be put in residential placements. So, a system that was meant to be meeting needs at different stages became a slide down. It is less so now, but the system was actually making some children much worse by not having the correct intervention.

66. What you had was almost always a significant family trauma, one that the child remembered. What was the impact on young people of several years of that bumping down through the system? No wonder they were angry and upset. What did we expect?

67. I genuinely felt that there were many young people who should never come to a place like Kibble. It was always a big campus. Although we broke it down into house units, it was still a big place, with a big school. There were about 90 to 100 pupils, including day pupils. We noticed in the early placement trends that young persons placed with us were falling into two distinct categories. They were youngsters who had sexually abused other youngsters, and youngsters who had been violent in other placements.

68. By the late 1990's I would say that two-thirds of the youngsters placed at Kibble fell into those categories. We had the biggest concentration of those youngsters by far, and we felt that we had to respond appropriately. We felt that we had to develop specialist residential units. That took a huge amount of research.

69. We had to think what to do with youngsters who had abused other youngsters. Should we put them together? Should we keep them separate, or alone? Keeping them alone would be a form of solitary confinement but if you put them with other youngsters what would happen? What would happen if you grouped those types of youngsters together? It was hugely complex.

70. By this point, around the year 2000, we had become a national resource for this kind of service. People realised that we were taking these youngsters when no-one else would or could. We were also building our charitable side, we were trying to get charitable money in, so as to not be dependent on our own resources because there was no local authority capital funding for us.

Policy development

71. Everything changed over time. Recruitment, qualifications, the training, the specialisation of services, the research base that we put into the organisation, and the staff that we had involved in international collaborations. We opened up the organisation. The organisation had been a traditional Paisley institution but it was quite closed. We opened it up. I was [redacted] for voluntary services. Groups met within the campus. While maintaining the integrity of the residential units, we tried to encourage a lot of community involvement and activity. That was a deliberate policy to get away from the idea of closed hidden institutions that could cover up things.

72. We wanted Kibble to be as exposed to the light as possible. You wanted people to be proud of working at Kibble, not apologising for working at the big, haunted house on the hill. You wanted people to be able to say that they were part of Kibble. We wanted to have the children out involved in the community. That informed the way we expanded the organisation and the facilities we rented or bought.

73. We were trying to break down the stereotypes of what residential care was and could be. Genuinely it always felt like a work in progress. We became a much more efficient organisation. I did not like what was happening elsewhere in residential care. I was always considered a bit of an outsider, partly because of my background, but as Kibble started to change, that attitude towards me gathered steam.

74. We were asked by one of the senior local authority figures if we would consider developing a secure unit in Kibble. That was monumental. We took a lot of pressure from all sorts of sides on that.

Strategic Planning

75. Strategy informed what we did. It did not happen by accident, we were working to plans all the time, about how we would roll out different services, the kinds of models we would have in terms of residential units, the qualifications of the staff, and about how the staff would be supervised. We had to think about when staff were working in a unit where we knew that most of the young people were not only the victims of sexual abuse but were also the perpetrators of sexual abuse. What would be the impact of that on staff? What kind of expertise do you build?

76. On the training front, we felt that this information needed to be shared much more widely. As part of our international work, the charitable trust paid for me to make international contacts with experts and specialists in the field of residential care. There was an expert on trauma who came, and we organised a big event for him to speak at, and we opened it up for everyone to attend. We were really trying to get an understanding of what trauma was, and how it was impacting the youngsters that we were routinely dealing with. The expert spent time on our campus and did training sessions with our staff. We put it onto our raison d'etre in the early 2000's.

77. At the same time, in my personal life, my wife and I had been married for 24 years but we could not have children. In 1999 we decided to adopt and applied to do so. We were approved for three sisters who were three, five, and seven years old. Their lives had been pretty grim, so I was gaining another understanding of trauma. At Kibble, we then started to look at fostering and adoption. We realised that, in many parts of Europe, fostering and adoption were linked to residential work, not field work.

78. I got a [redacted] Fellowship grant in 200[redacted] and did international travel for a two-month study trip to study fostering and adoption. I said that I wanted to explore fostering and adoption not just for what it meant for my wife and I as parents, but as a family and also for my role as SNR [redacted] at Kibble. The fellowship agreed to fund the trip not only for me, but for my wife and our three children. This was to allow us to see how we could develop a fostering service at Kibble. That was the beginning of that service, which continues to this day at Kibble. It was a specialist fostering service,

having regard to the trauma. It was not fostering babies, it was fostering older children who had experienced difficult circumstances.

79. As a result, the training for the foster families became the same as the training for our staff, and the foster parents had to get the same qualifications, because we felt that if foster carers were being asked to do the same kind of work as our staff, they should have the same training. Sometimes this fostering was a way for us to avoid any kind of inappropriate placement. These were children who were particularly young or vulnerable, but who had sexually abused other children, or had been very difficult in other placements. They met the criteria for Kibble, but we did not feel that a big residential campus was appropriate. Sometimes it was a straight diversion, and other times it was for youngsters who had been in Kibble but did not have a home of their own to return to. When you start to look carefully at kids who are seriously trauma affected, you start to discover that family ties are very thin, or non-existent.

80. We were starting to differentiate our services at Kibble. The old days of one-size-fits-all residential placements was gone. We wanted to try and understand what a youngster really needed when they came to us. We were trying to lay out in place, all the systems of staff support, staff scrutiny, and staff training. At the same time, we became aware that that concentration of young people would be almost unique in the United Kingdom. As one senior council official told me, "You're the only person I know who swims towards the deep end, everyone else swims towards the shallow end."

81. We were trying to stay true to our mission, as we saw it, and take the youngsters who had been excluded. We were far more frequently declining to take some young people where we felt there was an alternative. This work was not being done by me, it was senior colleagues who were doing the screening work, and they were absolutely brilliant at looking for alternatives to Kibble.

82. I can say with absolute certainty that we were full of integrity when we were looking for placements, because we were beginning to charge a premium price for accommodation. Kibble was setting it's own prices for placements, and these were dependent on the level of the resources required to work with each particular young

person. Where youngsters had extra needs, we were just saying that we were not prepared to take on a youngster unless the local authority were prepared to pay. Often the youngsters were coming from local authority care which cost way more than Kibble, because local authorities had set up specialist units.

83. What we had by the beginning of the 2000's was segmented services, breaking down the barriers between fostering and residential care, and still doing our day services. Our day services were providing evening and weekend services that were designed to try to stop young people coming into residential care. As well as young people coming to Kibble for these day services, we also had staff going out into the community.

84. We described ourselves as a multi-function centre for young people, not just a residential service. The entry level qualification for us to work with a young person was if they had had at least three placement breakdowns.

Strategic planning on the potential for abuse

85. We were an independent school. We were non-aligned. There were a lot of reports about abuse in the Catholic schools at the time, not only the Catholic schools but they did figure quite prominently. No one knew what was happening, but we knew enough to kind of say that was not how we wanted our organisation to be, so that was always informing a lot of the things that we did. A lot of things we did, we did because we believed them. We knew they were not being done elsewhere, and we felt they were contributing to all the difficulties of these places. This is why I have talked extensively about training.

86. No training encourages abuse. To us, poor recruitment, poor checks, poor screening, insufficient probationary periods, and nepotism encouraged abuse. The policies that we had at Kibble ran right through like words in a stick of Blackpool rock. We tried to make Kibble open, and I never felt you could do it in one way. I think that people who want to abuse children will find all sorts of different ways to do it. I think you needed to have floodlights coming from all directions at the issue, and that is what we tried to do.

87. At the same time, we were saying that we would work with the most difficult kids, so right away our statistics for any kind of critical incident such as absconding, physical interventions of any kind, or self-harm were elevated. It is like measuring a hospital by the number of people who die in acute care and saying, "That's terrible." We were also saying that we had to be the very best at things. We were informing these things from international practice.

88. We had projects regarding physical restraint that was part of an international study on what was happening with the physical restraint of youngsters, and what was happening with isolation and exclusion. We were trying to modernise. I am sure that there are areas that I must have missed, but I cannot emphasise enough that we tried to be as comprehensive as possible in every area of what we did. Our board was not mealy-mouthed about things. Our chairman and chief executive had a close relationship with us. Because of his legal background and the cases, he had dealt with, Jimmy Jack the chairman was absolutely adamant that we were going to be a transparent organisation that was going to open things up, as much as you could beyond reproach.

89. The administrative arrangements cannot be understated in relation to the quality of services that you can deliver. Kibble had a notional relationship with the Royal Bank of Scotland, they did the banking for us. Kibble always had a strong local bias. All the trustees were from Renfrewshire. For three years we operated hand to mouth, in a financial sense, but we decided that was our opportunity to change how we did things.

90. We started to take on the idea of evidence-based practice. Residential care tended to function for years and years without anyone thinking what works, what does not work, and what do we know? There were occasional changes, but there was no coherent understanding of residential care. There was no research, and there was no understanding of what kinds of children ended up in these places. The only determination was that they were children who caused trouble.

91. I can still remember the headline statistics, that 85% of the young people had multiple adverse experiences. People were not using the word trauma at that time. We started trying to explore the word from this research. That same group of young people all had more than three residential placements, and when you looked back, the average age of first contact with the social work department was seven years old.

92. Everyone had operated the Approved School model on the basis that you had teenage offenders, but the research was saying that what you had was children who had experienced multiple trauma at an earlier age. That really formed the basis for what we then went on to do. Although we went independent in 1996, it was not until 1998 that we began to understand who we were really working with, and as someone who worked in the system, I am aware of how terrible that must sound. That realisation began to change things.

93. That is why we did what we did at Kibble. We wanted it to be evidence based. We looked, and as far as we could see no-one else in the United Kingdom seemed to be building their organisations in the residential care field on evidence, they were building it on anecdote and whatever was needed at the time, but there was no planning. We consciously set about the idea of evidence creating practice, not just evidence-based practice. What we started to do was not what anyone else was doing with a kind of institution-wide approach. At its poshest, the term would be social innovation. We saw it as evidence informing practice. We were going to try and find out what we could and then build approaches on that.

Staff structure

94. I was SNR [redacted], and we had heads of departments. We had a head of social work, and a head of education. When the secure unit opened, we had a head of secure care. In my time, these were all executive director positions. That meant the department heads were on the board, and we all reported directly to the board on a monthly basis. The board from its inception in 1996 took monthly reports from all the senior staff about every aspect of the running of the organisation.

95. Below the senior managers, the staff structure varied across the different areas. In education there was an education structure that mirrored the structure of a special school. The school was still inspected as a school, and had to operate as you would expect a school to operate. There was a deputy headmaster, there were principal teachers, and various subject teachers at both primary and secondary levels.

96. One of the things that we tried to shift away from was the practice of the old residential schools. The care-staff, or houseparents' or whatever they were known as, used to play second fiddle to the teachers. The old units were also staffed in the evenings and at weekends by teachers on overtime, which I felt was never good practice. It did take a while to shift, but we moved away from that to proper designated care staff. On the care staff side, it was allocated against all the different types of residential units we had. There would have been a structure. We would have someone who had responsibility for two or three units. I think the job title was senior residential unit manager.

97. Usually, there would be a senior care worker running a unit, with unit staff. There would also have been parallel staff for the community services which were a smaller part of what we did, but there was always a team of community staff who reported in different ways. The units reported to the executive directors. Over and above that, as an independent organisation, we had our own cleaning, catering, and administrative staff. From 1996 we developed more charitable activities, where we had staff engaged in fundraising and so on.

98. The staff at Kibble were like staff in residential care. Very few people made a career choice to work in Kibble. If you had a brain, you did not make it a career choice to go and work in residential care. There were no entry qualifications. The great phrase was, 'We want life experience.' I am not decrying life experience, because I think a blend of life experience with good training is absolutely essential. That became much more marked as we developed more specialist services.

99. We talked about the trauma as we began to understand it and unearth things that had previously been hidden. People became opened up to trauma, so there was vicarious

trauma affecting the staff as well. I do not know if there has ever been a study on suicides of staff in residential care, but I know of many early deaths because of the kind of self-abusive lifestyles that people can slip into. Residential care was not populated by people like that, but it attracted the kind of wounded healer type of person. I suppose I was like that, the kind of person who wanted to give back.

100. There were undoubtedly people who just wanted to control, and clearly there must have been people who wanted to abuse children. For people who were looking to perpetrate any kind of sexual abuse, it must have been clear that this was the kind of place you could go, because staffing levels were so low, and the supervision was so low. There was the fear factor on the part of the children, and the control of the children.

101. All the ingredients for abuse to take place were there, but no-one would acknowledge these kinds of things existed. I used to call the staffing set a Dolly mixture, people from all kinds of backgrounds. There were loads of people who were very well-intentioned, and people who thought, "Well, I managed to bring up my own kids." But sometimes people who brought their own kids up very well were the people who were least able to bring up other children. That was something I never quite understood. There was no rhyme nor reason to the staffing, really. Attempts had been made. Newfield Assessment Centre went for a kind of super-qualified, trendy social workers in the mid 1980's and they got eaten in this environment of having no kind of ability to manage.

102. With reference to the initial staff at Kibble, there was a lack of qualification, but Kibble probably had more qualified staff than most. It certainly had more qualified staff than Kerelaw. The senior staff at Kibble tried really hard to get training places. There were one or two training places available a year. Of course, a training qualification then gave you eligibility either for a promotion or to work outside the sector. The training was often a ticket out of Kibble.

Recruitment of staff

103. There was obviously a time of staff recruitment that was pre-regulation, as well as post regulation and I dealt with both. What I can assure you of is that in the pre-regulation time we tried to be good at it, but as soon as the regulation came in, we always tried to be ahead of the regulations. We used the regulations as our base line. We had an extended probationary period, which was two years.

104. That then became a challenge under employment law. We formally linked the probationary period to qualifications. We also insisted that people became employees of the organisation, not a part of the organisation, so that we could re-deploy people across the organisation and stop any sense of things in any area being too closed off.

105. That policy caused huge challenges when we opened the secure unit because we insisted that every staff member had to be able to work in either the non-secure units or the secure units, because my experience in secure units and what we had seen happening elsewhere was that we saw how such institutions became closed institutions. I was raised on all the negative stuff about institutions, such as Erving Goffman, and his book called Asylums. These kinds of influences were very strong in our minds about how we were trying to shape an organisation.

106. We were linking recruitment to character references, personal references, police checks as soon as they became allowable, and training and development. People had to be trained to keep their job. To me, the number of local authorities who did not do this was a scandal. We were one of the few organisations that absolutely enforced it. That is why we had one of the highest number of qualified staff in the sector, by some distance.

107. Initially, a lot of the staff at Kibble were quite local, but that changed over time for a number of reasons. It changes partly because we, as an organisation, raised the bar, so we had to go to a wider catchment area. We were trying to really understand staff. In trying to improve staffing we made a pitch to Renfrewshire Enterprise, the local

enterprise company, that we were a big local employer. In fairness, they did come around and gave us money for training.

108. That funding allowed us to ramp up the kind of training we could do, and the care we could take with recruitment. We had to understand where everyone was coming from. There was all sorts of data about the background of workers and the areas they were coming from. We had to have them all by local area postcode. The reason for that was linked to funding. This is when we were ramping up in preparation for the secure unit opening, which was going to add another sixty or seventy staff and that was a huge change.

109. We had been adding a service every year and that allowed a phased programme because those additions were much smaller services, but the opening of the secure unit was a massive change to bring about. We had to have all our figures ready for Renfrewshire Enterprise. We had to explain what we were doing and why. We explained that we wanted a much more developed workforce. Renfrewshire Enterprise were very good for us in helping us to develop this because we were offering so many local jobs.

110. One of the unintended consequences of this action was that we started to get a hugely disproportionate number of women applying. By that time, we were a co-ed institution, so we wanted a balanced work force. We had about three times more women applying than men. With exceptions, women tend to be more articulate than men. Women often present much better in a care setting but we felt we needed to have a balanced workforce.

111. Our preferred scenario, based on the young people we had, was a ratio of two women to one man, but we found that incredibly difficult to do. We set up a specific recruitment program called, "Men can care". We wanted the title to reflect the work. We got European funding for that. We got equal opportunities funding for it. It was the only equal opportunities program in Scotland at the time that got funding to support an imbalance against men. The program had to be very well documented and was re-evaluated a hundred times. We wanted to make it so that the men were not seen as

being there for the physical control, they were there for the care. We ran that program twice and it got UK coverage for its success in bringing men into the care workforce. More than fifty men were recruited to Kibble through these two programs.

Staff accommodation

112. There were residential quarters for staff on site at Kibble when I arrived. There were three houses at the front that people had been living in, but these were sold. I did not like the idea of people living on the site, for a variety of reasons. One of the questions under consideration was to what extent should a residential establishment play at being a home? That was something that we felt we should not pretend to be. We had heard complaints from parents that Kibble undermined them, because they were poor and could not afford to do some things we did. However, we also had to consider the children who did not have family.

113. Although we did not continue to have residential accommodation for staff on site at Kibble, in the very early days there was a thing called, 'sleepovers.' It was a standard thing in residential care, where you were on duty but given a room to sleep in. I did it myself in my younger career. These sleepover arrangements did not last long. They stopped around 1996. After that, nightshift staff were awake, with an on-call system. As the organisation grew, we developed a two-tier on-call arrangement, just because of the sheer numbers of young people.

Staff training

114. What we set about doing for children at Kibble was to try and be the placement for them, when all else had failed. That worked for, probably, most of the youngsters who came through Kibble. We set ourselves the conscious task of holding on to young people and adjusting the services around the young person, as opposed to the young person being put into whatever was available.

115. We tried to be much more bespoke about services. But we realised that if we were going to have that group of young people, we were going to have to have the best staff

in the sector. Very early on, we put inordinate amounts of money into staff training and development.

116. Everyone had to do ongoing training. Latterly we had continuing professional development, CPD. That was mandatory for registered workers. We were trying to retain everyone. We had team training days all the time. These were allocated and scheduled into the calendar. One of the non-executive directors that was brought on at an early stage was someone who had previously been responsible for training in a local authority, at a senior level, but had retired early because he felt he was not getting anywhere. He insisted that all of our training records were fully up there. So, these numbers would have been reported on in terms of what you were doing about supervision, and what you were doing about scheduling time. It was a huge challenge, but it was always a fundamental part of our organisation.

117. We also carried that training into all of the ancillary services, because it was also not uncommon in a lot of residential establishments that ancillary staff were very actively involved in care. We always felt that our ancillary staff needed to be, not only well vetted, but well trained in their job. It also gave them "buy-in" to the organisation. I was often told, "If you train them, they'll leave." but that was never our experience. Our staff retention rate, for many years, was double the sectoral average. That was at a time we were doing the most training because people felt valued.

118. I can say that throughout [redacted], from 1998, that Kibble had the most qualified staff in the sector across the United Kingdom. In any residential setting, Kibble had the most qualified staff according to the regulatory requirements for staff. That was steadily rising, but we were always at the front, because I felt that if we were going to work with the youngsters who had the most challenges in their lives, then we had to have the staff who were best equipped to do that.

119. To get that level of training through, there was a huge level of supervision and enforcement involved. People talk about training as if it just happens, but to make it happen you had to cover shifts, you had to allocate time, and you had to have work-place supervisors. It was monumental, and it had to be priced into the way the

organisation ran, and we did price it in. By the year 2000 it was priced into what we did.

120. There did become a minimum qualification for staff. The first inspections were in 1992 or 1993, around the time when I [redacted] at Kibble. There were certainly no requirements for staffing qualifications until the early 2000's. When that came in, I went onto the Scottish Social Services Council Workforce Committee. We wanted to practice what we preached, by insisting on minimum standards and trying to go beyond them. In [redacted] at Kibble, you would not read any report saying that we were not at the required staffing qualification level.

121. The minimum qualification for staff became a Scottish Vocational Qualification, SVQ3 with Higher National Certificate, HNC. Way back in the 1990's there had been all these lofty ambitions that everyone in residential care would be social work qualified. There is no way that was ever going to happen. For a start, a social work qualification would not have been the right qualification. My social work qualification only gave me one three-week residential placement. That was the only training in residential care that I got in my qualification. I am not saying that the other training I did was not relevant, but I did a lot more that was irrelevant to my career in residential care, than I did of things that were relevant.

122. I felt that some of the comments about training were just meaningless aspirational statements. To me, if you set a goal, it has got to be achievable. Every year we would set ourselves targets on qualifications, and that target qualification became the SVQ3 with HNC, within two years of qualifying.

123. There was a huge workforce deficit. There were no people sitting around with an HNC qualification, and an SVQ is a vocational qualification that you have to earn within a job. Very early on we partnered up with other bodies. I then became involved with some of the Catholic schools who were trying to increase their training numbers as well. There was a charitable company limited by guarantee called CCC training, and I was a [redacted] of that. We shared training to get the numbers up.

124. This was all happening around the time of local government restructuring, and that was matched by a sucking-out of any qualified staff local government could get their hands on, because there was a shortage of qualified staff in the social work workforce. The local authorities lowered the qualification tariff for social work personnel. The old qualification was called the CSS, the Certificate in Social Studies. It was previously only relevant for social work, but because of the shortage of staff in field social work, they made the CSS a relevant qualification for field social work. That sucked more people out of residential care.

125. Given what we now know, and the work being done by The Scottish Child Abuse Inquiry, it seems incredible that for decades there was no systematic approach to training and development of staff in residential care. As I have said, it was the reverse. They were literally sucking people out of residential care work because those people had a qualification, and the attitude was that you only needed life experience to work in residential care.

126. From 1996, we ramped up training dramatically, and I can say unequivocally that Kibble had the best trained staff across multiple disciplines, not just the care staff. I do not believe that training obviates criminal or deviant behaviour, but I do think it reduces those risks because it brings a lot more things under the spotlight. I think it gives people skills.

127. I was not involved in administering the staff training, I would participate in the staff training in different areas, such as child protection, therapeutic crisis intervention, and health and safety.

128. By the early 2000's we had a full-time designated training team in the organisation. They had responsibility for both professional development training and for statutory management training. That was in place until the day I left. Obviously, it was a matter for the senior staff to decide on the time and budget allocations for training, but seldom the detail, other than it had to cover everything.

129. There was never a time when there was a big pool to draw from that you could say were qualified workers. That never existed in my forty years of working in the residential care sector. Any staff that were trained, were usually trained because you had recruited them from some other organisation, or they were staff that we had recruited, and they had to fulfil their training as part of their on-going employment. Graduate intakes were never a feature of residential care.

130. The training we had was not abstract training. To be honest, mine was probably the most abstract training. I am not saying that flippantly. As apparently the person with the most qualifications, I tried to learn on the job.

Staff training dedicated to educating staff on how to deal with children with complex needs

131. The training for residential staff was split into two parts, which were workplace assessment and day release at college for an HNC. So, the vocational qualification was in-service, and it was always tailored to what you were doing in-house, and the assignment work that people did was geared towards workplace situations. That is why they are called vocational qualifications. That was why we felt we needed our own training team. The work on the vocational qualifications was hugely time consuming. Unless organisations made a monumental effort to make it happen, training tended not to happen.

132. Our training team both carried out training and organised external agencies to do training. It depended on the nature of the training. From around the time that Kibble opened its secure unit, which I think was in 2007, there was a whole debate that came out of the prison service relating to training regarding programs and interventions. There was mandatory training around programs and interventions. There then became a whole thing about programme fidelity, meaning that if staff are not trained then you are not licensed to deliver the program, or say that you are a registered establishment.

133. Despite all the discussion, these programs were dropped, and Scotland was never going to make them mandatory. However, we adopted them because we were doing

such specialised work. We developed some people who became licensed practitioners in relation to these programs. There were different licensing bodies, depending on which program was being used. There was someone who dealt with fire-raising issues because we regularly had young people who were fireraisers. There were some who were practitioners in relation to sexual abuse because we dealt with children who had been sexually abused. There was a whole thing around advanced therapeutic crisis intervention, which was called life-space crisis intervention.

134. We trained staff up to the level of being licensed practitioners. In turn, they could provide training, but we had to have strict training records in place. They would often report to an external trainer of trainers. However, we felt it was better to develop our own programs. In the specialised areas, we were working with young people, we wanted to have people who were at the top of their game. In a lot of these areas we were plugged into international networks, we were not talking about the best practice in Scotland, or even the United Kingdom. It was part of trying to encourage people into the establishment.

Training in relation to the restraint of children

135. I think it was around 1992 or 1993 that training in relation to the restraint of children entered the training scheme. It was one of the first things that I pushed on at Kibble. In fairness, it had already started in some of the local authorities.

136. Things that became known as abuse, where there were physical interventions, I know were instances where staff were sometimes literally fighting for their lives. Staff were being attacked and were then accused of punching or hitting kids. Sometimes that was literally self-defence, which was the line that the police and the courts would take, but not, sometimes, social work investigations. I felt that if you had trained staff, all these kinds of things could be helped and reduced. Also, we were saying that we were going to take the young people with the most profound complex trauma and associated conditions of anyone. We were doing this on multiple fronts. The research of who we were working with became pivotal for us. Then we began to see placement trends.

137. The restraint of children was always a hugely challenging field, for all sorts of different reasons. You could not have staff not doing it, and there were always people who did not want to do it, but you could not have that. You were always wary of the people who were full-on for it. It was a bizarre kind of paradox. There were psychological and physical impacts upon staff. There were significant physical standards to be met, and that led to the issue of examining people's physical fitness for the job. On a couple of occasions, the physical fitness of a staff member went to an industrial tribunal.

138. Physical fitness for the job was taken into consideration when someone applied for a job. It became a very open topic of discussion at recruitment, that a person would have to train in physical fitness for the job.

139. There were two training systems in Scotland, both of which were from north America. Both became approved systems. Because of what had been happening in residential care, these systems were beginning to come under scrutiny. There was a smaller system that was led by Lindsay Patterson at the university of Stirling, but I cannot remember the name of that system.

140. The other system was called Therapeutic Crisis Intervention, TCI, which came out of Cornell University. That tended to be commonly adopted throughout the United Kingdom. I am not going to say that it was an industry standard, because it was not. My recollection is that most people knew that they had to do this in their establishment. Due to the notion of programme fidelity, it became a very managed system. Staff had to follow the system, pass the physical test, do the practical test, and then they would get a certificate. My recollection is that it was a four-day training programme.

141. In order to ensure that a staff member kept up to date with training, the notion of programme fidelity meant that they had to undertake annual updates to their training. Programme fidelity was a huge effector for a variety of reasons, mostly because of the kind of young people we were dealing with. We felt that it was absolutely paramount that we were at the front end of programme fidelity with records and other aspects of care.

142. Regarding the scenario of a staff member who had completed the four-day training in order to become certified, and then failed annual training, that might have had implications on staff who you had asked to leave. Restraint training might have been one of the areas being considered in such a decision. Sometimes people self-selected exclusion from work due to being unable to cope with the psychological or physical aspects. Sometimes it was both.

Supervision / appraisal / evaluation

143. Every team had a weekly staff meeting. It was a scheduled meeting, and minutes of the meeting had to come up the line. There should also have been supervision notes recorded that were obviously private. There was always a debate about the confidentiality of supervision notes. There was always meant to be a recorded note, or even a diary entry to confirm the event took place.

144. Then, we had what we called inter-disciplinary teams. For example, teachers and care staff. We had a way of allocating different teachers to different units. You can imagine that with different schedules and timetables, that would affect when you could take different teachers to different units. There were overlap times for teachers. Then, we had meetings for groups of care staff, by section. Occasionally there would be a whole staff meeting but they were often too difficult to arrange.

145. Kibble was constantly open around the clock every year. As far as we could see from the records, Kibble had never closed since it opened in 1859. That was a monumental thing to do. It always annoyed me how 9 to 5 workers never appreciated the sheer challenge of keeping a place going around the clock.

146. I was [redacted]. We had one-to-one meetings. All of the senior staff would meet [redacted] at least once a month. We had a daily briefing because of the round-the-clock nature of the organisation, often with high-risk major incidents. We had a weekly formal, minuted staff meeting. The minutes of those meetings went to the board of directors, so there was a huge document trail relating to supervision. There was also professional development, particularly for the senior staff who were meant to be at the front end of continuous learning, as we called it. Again, the board

of directors was always aware of our continuous learning because that had to be reported in the board of directors' reports.

Children / Routine at Kibble

147. My day-to-day involvement with Kibble was such that the place would have run a treat without me. Day to day, my involvement would have been peripheral. I was from the generation just beyond the autocratic SNR [redacted]. I had huge reservations about how those people ran places such as Kibble.

148. All the management were based on the campus. There was always a designated duty manager. That was not always a senior manager, but in that event a senior manager was always on call. We were out and about on the campus, we ate on the campus, and we were coming in and out of the campus at all times of the day and night. I tried not to change the way things were running, I tried to be a presence there.

149. I do not think that you can formulate strategy for an organisation unless you know what the organisation is doing, what it does well, what it needs to do better, and what it needs to completely abandon. I felt that being embedded there was absolutely fundamental to being my best as [redacted].

150. I had personal interaction with the children all the time. I would see them coming and going. Some would know me as [redacted], others would be completely disinterested.

How children arriving at Kibble were made aware of behavioural expectations

151. Each residential unit would have meetings where they would talk about things and plan things. Everything was underpinned by interpersonal relationships. We tried to constantly discourage a rules list on the wall. We managed it for most areas, but never the kitchen. There was a constant and increasing effort to make Kibble a family unit, without trying to pretend it was an alternate home. It was to be a homely living unit without pretending to be a family home.

Accommodation

152. In 1996 we were dealing with physical accommodation stock, with some exceptions, which had been there for up to twenty years. Some of the old classrooms were being used as bedrooms by then. As well as trying to re-invent how we approached things, we were trying to re-invent the services we had developed as a charity, and to fulfil what we saw as our charitable mission.

153. There was a political phrase going around at the time which was "back to basics" and we called what we saw as our charitable mission our back to basics of what the charity was about. We managed to get a very large grant from the National Lottery. It was £500,000. It was a below-the-radar grant, they never publicised it.

154. It was agreed that we would use the grant money to build two eight-bed units in one building but split and operated as two units that would work with young people who had sexually abused other children. The units were opened by Princess Anne. This was us trying to establish ourselves as a mission-driven charity, not as an arm of local government.

155. Kibble expanded beyond the campus. When I left, there were four off-campus units, and nine on-campus. There were also between sixteen and twenty foster placements. The different residential units had different names. The tradition had been Scottish islands but as Kibble expanded some units were named after areas of Paisley.

156. The people who had access to children's residential accommodation were the children, the residential staff, and the ancillary staff. Visitors and teachers might come in and senior staff would visit. At night, the units were locked from the inside. That was because of our location. It was not unknown for there to be forages into Kibble from Paisley. For a period, break-ins were more common than breakouts.

Schooling

157. Kibble was a residential school. Disproportionately there was much more of a focus on what you would call personal, social, and moral education. That was always by our choice. We tried to weave that into what was happening within the living units. There was a phrase in the 1980's which I think was called 'total education', which meant that there was no distinction between the school element and the residential element. The whole of Kibble was meant to be a place of learning.

158. The senior staff felt that the concept of 'total education' was not in any way normalising behaviour for young people at Kibble. Many of the young people we were dealing with had been out of school for as much as five to seven years. There were often special arrangements we needed to make for children to adjust to school. School had a big part of the formal aspect of expected behaviour. Then, there was the program of respect.

159. In relation to the role of teachers in residential accommodation for young people, in the mid 1990's they still had quite a prominent role. Teachers were very well paid, because not only did they get a teacher's salary, but they also got an additional allowance for working in a residential institution. They also had guaranteed overtime hours.

160. We insisted all our teachers were qualified teachers. One Friday afternoon, three teachers had some kind of street-fight between themselves, out-with Kibble. After due process, I sacked all three teachers. We had put all this effort into training people in measured restraint, and here were three members of staff rolling around in the street. I felt I had to take a stand on that. That incident was hugely disruptive because we did not have that many teachers. I felt that if we were trying to create a climate where violence was not the norm, we would have to have standards. My experience was that young people were often so traumatised and their behaviour was often so difficult without involving violence that we did not want to do that.

161. You can imagine the impact of this change in policy on the organisation. It probably set us back. We were trying to say that our policy, as an organisation, was that we would not tolerate violence. In an atmosphere where violence is often evident, where some young people were considered to be very dangerous, it was hard to have the right kind of tone. A tone that was not about repression but was about safe control.

162. The message that change of policy sent out in relation to recruitment fundamentally changes the kind of people who are attracted to working with you. The policy change meant that we were specialising our units. We were taking care with our recruitment and the training of our staff. We were saying, "These are our limits. These are the things we will not do." I appreciate that you have to look at individual aspects of policy and practice, but they really do all weave together. One of my colleagues referred to it as a moving mosaic. In an organisation like Kibble, it felt that it was always moving, and we wanted it to be improving.

Discipline and Punishment

163. When I arrived at Kibble the approach was one of rewards and sanctions. It was the approach used in many residential schools. That was usually in the form of credits earned or lost for pocket money. When pocket money was outlawed, it became credits or debits in relation to outings and activities. It was an attempt to normalise discipline to a more family-based routine. That evolved.

164. We tried to discourage the use of rewards and sanctions. The idea that, "If you break a window, you pay for it." was unworkable when the window was a sealed unit that cost two or three hundred pounds. The push was to try and have relationship-based influence on behaviour, with keyworkers for young people. That did not always work, because sometimes there was no relationship between a young person and a member of staff.

165. For example, the way that a young person kept their room, or did not keep it, could result in discipline. Also, how much damage was being done to the room. One thing that we found surprising was that as we moved away from dormitory accommodation

to single en-suite rooms, was how the standards improved, because the young people had a sense of ownership. As we changed the physical structure to individual rooms across the campus, many of the things that had been huge issues around reward and sanction almost vanished.

166. We tried to avoid a set response to disciplinary matters. We did not allow a tariff system, we tried to be much more flexible. Many of the young people who came to Kibble had a well-established background of being hugely disruptive. It always took time for these young people to settle in. A lot of young people lost control of themselves, they felt so unsafe towards themselves. They were out of self-control. That required the proper training around how we used TCI and such like.

167. In [redacted] around 2010 to 2012, we changed from Therapeutic Crisis Intervention, TCI, to another licensed system. We felt that TCI did not have any basis in research. We felt it was too limited. We felt that another program called Safe Crisis Management, SCM, which was not just about how you intervened in a time of crisis, would be better.

168. SCM was another licensed system. It meant that when we did intervene at times of crisis, we were trying to utilise the goodwill assets and the relationship that we had built up with the young person over time. I am pretty sure that is still the system that they use at Kibble, it was certainly still in use when I left. It involved much more work in learning from what was working and sharing amongst practitioners.

169. We did not have a centralised code of conduct around how young people were expected to behave at Kibble, or how staff were expected to sanction bad behaviour. We did have a big push on respect for each other, but we never called it a code of conduct. Respect became the language of how we interacted with young people. That was meant to work both ways. Staff were being held to a respectful approach as much as the young people. That applied to the hierarchical line management arrangements as well. In dysfunctional organisations, you find that there are dysfunctional hierarchical arrangements and that dysfunction is mirrored.

170. There was a Care Commission requirement that we did have to note anything that would have come into the category of sanctions. These had to be recorded in a log. They were subject to inspection. I am sure that was one of the earliest interventions from the Care Commission, because of the concern over the inappropriate use of rewards and sanction.

Staff autonomy in relation to the imposition of sanctions

171. The staff would not have had much autonomy about the imposition of sanctions, that would have been something that should have been supervised. It would have been the job of the residential unit manager to track this, which they did routinely to make sure that there were no disproportionate rewards or sanctions. Frankly, your antennae would go up if a young person was either being particularly favoured or particularly put on by staff. You would ask, "Why?" Being aware of the daily interactions between staff and young people was absolutely integral to the unit manager's job. They would not only be referring to the written logs but using their powers of observation.

172. It was never the case that sanction, or discipline, was the responsibility of the older children to impose on the younger children. That is how the old places ran. In the 1980's the attitude was, "Pick the big one, make sure they know you're boss, and it will go down the line." With the staffing that there was at that time, that was probably the only way that any semblance of control was kept. In the 1970's and 1980's you were often talking about residential units of 25 young people and one member of staff.

173. We did not have any system of prefects in the school at Kibble either. Although we tried to make the school as main-stream as possible, we felt that it was not appropriate to have children in a position of authority over other children.

174. If a child absconded and nothing happened then there may not be a formal sanction, such as restricting access to a trip. Sometimes the children would say that it was worse getting a strong talking to, or a long lecture. A lot of time was spent on post-absconding interviews. Sometimes these became more complex depending on what happened when the young person absconded. For example, if a young person had been trying

to break into houses locally. Sometimes young people absconded because they just wanted to cool off. They would go away by themselves and come back.

175. The issue of absconding became much more complex when we started to have residential units that housed sixteen young people who were there because they had sexually abused other young people. In those circumstances, their whereabouts became absolutely paramount. In some cases, they were the subject of an order that required immediate police notification. Sometimes there was latitude in notifying the police, sometimes there was not.

Isolation/segregation as a form of sanction

176. I do not think that there was ever an isolation room at Kibble, but I am going to qualify that statement by adding that there was a spare bedroom, number nineteen, in the secure unit. We tried not to use that room for punishment, but it might have felt that way to a young person. If you had a whole corridor of young people who were all settled and one young person kicked off making a lot of noise, they might be moved into the spare bedroom in a separate area to stop disruption.

177. That spare bedroom was used if there was major damage done to a young person's room, or if a young person was attempting to self-harm. The rooms were supposed to be suicide-proof but that turned out not to be the case. There was a suicide in a room in one of the secure units. I cannot recall the name of the young person involved.

178. Sometimes young people would be sent to their rooms, but as the bedrooms had no locks, there was no way to physically enforce it, other than by the presence of a staff member being with the young person. The spare bedroom in the secure unit did have a lock. One of the reasons that we had to do massive staff training was that staff needed to know that what happened in the secure unit was legislatively different from what happened in the open residential units.

179. A child from the open units could only be transferred to the secure unit if there had been a critical incident and the director of social work for that young person's local

authority area agreed with the designated member of staff on duty that there was a need to put the child in secure accommodation. That happened under a system called administrative process. That had to be formally ratified by the children's panel within 72 hours.

180. Sometimes dangerous things would be removed from a bedroom if a young person was sent to their room. Sadly, sometimes children would destroy their most treasured possessions. Staff became quite good at taking away the things that young people did not really want to destroy but might do in the course of venting their frustrations.

181. The spare bedroom was also used because of routine servicing. We had to keep rooms functioning. The spare bedroom in the secure unit was never referred to as an isolation room, but I am not so naïve as to think that it did not feel like that.

182. The practice of sending someone to their room was not something that would work in a dormitory. That was another reason we felt we had to have single rooms. Do not underestimate the time and money it took to pay for all the accommodation to be single rooms that were en-suite. A couple of other places had been built in that way, but we were at the front end of places that were retrofitted that way.

Restraint

183. I think that in 1992 there was a bit of a discussion about training for restraint techniques, but that was the first time. Apart from that it was a free-for-all in how to deal with restraint techniques. We were using restraint for all sorts of reasons. People seem to imagine that that just means restraining one child, but we were having to use restraints where there was child-on-child injury, self-harm, and attack. I was having bottles, knives, and airguns presented at me, so I was having to use restraints, but no one was being trained at that time.

184. Restraint would principally be used if there was violence by a child towards another child or a member of staff. Every physical intervention by staff had to be logged in the same way that sanctions were logged. That was a Care Commission requirement,

latterly. I think the requirement to record physical interventions did not come in until the early 2000's. Every incident had to be evaluated and debriefed. That was initially a requirement of the licensing organisation. I think it then became part of the critical incident review arrangements. Reflective practice was inherent in these systems, and that was the reason we moved from TCI.

185. We felt that TCI did not pay enough attention to the data we were collecting. I cannot remember now what we were specifically concerned about, but we just felt we were sending information into a black hole, and no-one was looking at the reflective notes. We felt the other system paid much more attention to what we were learning.

186. What we learned was shared not only in the establishment but with other residential care providers, on an anonymised basis. We were able to look at the lessons we were learning in relation to restraint. That was sometimes to do with the antecedents, rather than the actual physical restraint. We would ask, "How could we have avoided a physical intervention?" We would ask about the technique, "was it safe?" We would ask how distressed the young person was and how many adults were involved.

Personal involvement in the restraint of children

187. I did have cause to restrain children in the course of my work. I have had more than my share of weapons presented at me in my career, both at Kibble and everywhere else I have worked. Not always, but most times, those weapons were presented not in a state of real anger, rather a state of distress. There is a difference. There were very few occasions when I felt that I was the actual target.

188. That became a skill of staff, to learn when a young person was angry at the world and not really going to harm anyone, and when they were going to harm someone. That is a hugely challenging decision to make, and different people will have different opinions. I am a big guy, and at one time I was a big young guy. What I could do with my presence, was very different to what other people could do.

189. However, larger males could sometimes be worse for that situation, which is again why we wanted a balanced male and female workforce. We felt that there was no evidence from our analysis of statistics that small women were at more risk than big men.

190. Regarding any instances of me witnessing the excessive use of force when someone was restraining a child. If a situation was running on for a long time, a senior member of staff would be involved, and if I was on-call I would be coming in at night, so I was seeing things and sometimes I would become involved in the restraint of a child. I know that some people would have modified their behaviour because I was present. I also know that there were many interventions that were done with great skill.

191. It is very difficult to determine what is reasonable force when a child has a weapon, such as a knife. I can think of an occasion, when I was working at Gilshochill, where I had to punch a young person to disarm them. It was when the young person was coming at me with a sword. On that occasion, I did determine that the young person had intention to cause serious harm, and I was in immediate fear for my life. To me, that was reasonable in that very specific situation.

192. Often the restraints were dynamic, they kept going with ebb and flow. I did not see people deliberately trying to inflict pain on a child, but I did see people having to take really serious action to disarm children.

193. In the 1990's, Stanley knives were endemic and caused significant damage. There was a situation where a staff member was very badly scarred by one. That did not happen at Kibble, but it was well known throughout the residential care sector. It almost became a trigger for people if a Stanley knife was present. The focus was to get the Stanley knife away from the child before doing anything else. Those kinds of situations were almost borderline. I knew that if you are in the arena, it is not going to be as clean and neat as the textbooks would have you believe.

194. People think that it is about technique when you are being trained in physical intervention, but the technique is the easy part. It is the psychological responses that

you make when dealing with a young person in the situation where restraint becomes necessary, that is where the training really makes the difference. I have seen some incidents that could have been deadly, but staff intervened in a superb way. That was because they were trained people. That was why, to me, the training was absolutely critical to what we decided to be as an organisation.

195. Staff had to do their restraint training within four weeks of arriving at Kibble. During that period staff were not allowed to be unaccompanied within Kibble. It became an entry level requirement.

196. There were instances of children being injured as a result of physical restraint. Bruising would be the most common type of injury. There would be the occasional fracture. I cannot remember anything more serious than that. Any injuries would be recorded, and you would also have a health and safety requirement to record any fracture through RIDDOR, the reporting of injuries, diseases and dangerous occurrences regulations. I would say there were a handful of such injuries.

197. The number of staff injuries was colossal. It became a bit of an issue for us with trade unions. Staff were not there to be sacrificed, and staff were sometimes required to deal with incredibly violent outbursts. Staff were sometimes being asked to take unbelievable levels of abuse and potentially deadly harm.

198. There were occasions where staff were charged by the police as a result of injuries sustained by children. I can think of two staff who were dismissed because of such incidents. I cannot recall the details of those staff members or the circumstances of their dismissals. One was definitely charged. In the other, the staff member was dismissed and did not appeal. The details of these would all be contained within records and would have gone through our board reports. I can guarantee that all such incidents would have been recorded.

199. There was a spell where the trade unions believed that only if people were charged should they face discipline. We did not believe that because there were practice differences.

Corporal punishment

200. Corporal punishment was never used at Kibble, it had been outlawed by the time I was there. To my knowledge, there was no form of physical punishment used against children at Kibble.

Reporting of complaints/concerns

201. As SNR [redacted] or SNR [redacted] of Kibble, I did have to deal with complaints of ill-treatment of children, made by children and made by staff. The number of cases I dealt with might seem low, but I was [redacted] of defence. We tended to follow an appeals process, and I tended not to be involved at an early stage. By that, I mean that complaints would have been reported, but not directly to me. I would have seen that something was happening because I would have seen the reports through our reporting mechanisms. Those would have been a mixture of reports made by children and reports made by staff. There were also reports made by children where they felt that other children were not being protected.

202. In terms of my direct involvement, that meant I was only dealing with approximately one case per year. If a case reached me, my normal course of action would be to go through it all again. I cannot remember ever making a desk-based decision on a case. It would always involve a replay of the information from whoever was involved. I would set up an investigation and meet directly with the people involved, including children if necessary.

203. Of the matters I investigated directly, there were complaints against staff members that were upheld. There were other cases where it might be felt that someone should undergo more training. There were sometimes debates about where employment law kicked in and we had to consider what went through the disciplinary records.

204. There were matters I dealt with which were referred to the police, but usually they had been referred to the police before they got to me. Due to the size of Kibble, there was

a designated police officer for Kibble, usually allocated from Mill Street police station in Paisley. They would be the person who was routinely notified of anything that came up. That police officer had a close link with the child protection officer from Kibble, alongside the Strathclyde Police child protection officer. I cannot recall the names of any of the police officers involved in that role. There were several officers assigned to the role during my time at Kibble.

205. If the police became involved in a matter, it was usually complex. It would not be something like someone being constantly late for work, which would be a straightforward human resources investigation.

206. If a child made a complaint against a member of staff and the member of staff was charged by the police, I can think of some cases where the member of staff was suspended. In some cases, they were assigned to administrative duties off-campus. A staff member would not be dismissed just because they had been charged by the police. However, a staff member could be dismissed even if they had been found not guilty in a court case.

207. We had to take legal advice and put a lot of thought into cases where someone was charged by the police. The police were saying to us that they were under direction to charge in every situation and let the Procurator Fiscal decide. They were following the letter of the law and were telling us that their discretion had been removed in that area. That was because, previously, it had been felt that the police had too much discretion and had been hiding things. Due to one particularly complicated case, we ended up taking extensive legal advice. We did not feel that it would be fair to sack people just because they had been charged.

208. I cannot recall any situation where a member of staff continued to work with a child after that child had made a complaint that was outstanding. I cannot be one hundred per cent sure, but I think they were always either suspended or put on administrative duties off-campus.

Trusted adult/confidante

209. If a child had any concerns at Kibble, then, officially, they could go to their keyworker, but children would often find their own person to talk to. We always allowed for that. Sometimes, it was one of the tradesmen. All of our internal tradespeople, such as the domestic cleaning staff, were all trained in child protection as well. Children were never told, "You can't speak to them." or, "You didn't speak to the right person." They could go to whoever they felt comfortable with. The same process would be followed regardless of who they spoke to. Children did raise concerns in that way.

210. We also paid for a person from Who Cares? to come and visit. They had a completely free hand to roam the campus. The Who Cares? representative could come and speak to us on behalf of children if the child did not want to say something directly to us themselves. That process was in place from the early 2000's. I think that was in place by the time we opened the secure unit. That service was paid for by us, but there was no management of that by us. I would hope that if you went to Who Cares? they would have their own records.

Allegations of Abuse at Kibble

211. I would be lying if I could say that I could be super-confident that if a child had been abused in Kibble that I would have known about it. How confident can people be in their own homes when abuse can occur there? Kibble was a big place. In [redacted], there were hundreds of young people and staff who went through it, across multiple units. We were in and out of the campus at all times of the day and night and there were spot checks, but I am not naïve.

212. There is no way I could say I would have known if there was any abuse, but I also know the tone and behaviour of places and you gauge a lot by the watching of relationships and seeing children going to school from their units, laughing and joking. These observations are soft and intangible. They are not enough to safeguard against abuse, but they are very important.

213. I have been subject to allegations of abuse. There was definitely one while I was [redacted] of Kibble, as SNR [redacted]. It was to do with a broken window. A young person alleged to a social worker that I had manhandled them, but I was not involved in the incident, I had no interaction with the child. The young person was alleged to have broken a window, but he said that he did not do it.

214. The matter was investigated by the board [redacted]. The board reported to the social work department about it. The board found that I had not done anything, because I had no interaction with the child. It was not a case of the board finding that I had acted appropriately, because there was no action by me. I still think that what probably happened was that another member of staff had interacted with the child, and the child thought it was me. It seemed a really odd case. He was not even a young person who figured on the radar. I was not constantly hearing his name in an adverse sense. That was the only such allegation against me at Kibble.

Child protection arrangements

215. Child protection was another area of mandatory training for everyone, me included. That would become part of your staff training file. That would all have been recorded.

External monitoring

216. Kibble is an independent organisation. Any monitoring that we arranged could be viewed as internal monitoring. Our board members did some visits, but is that external monitoring?

217. There was the Care Commission, the Care Inspectorate as it now is. They were regular visitors. There were announced and unannounced visits. As a residential school, we would have unannounced visits every six months or so.

218. When the Care Commission visited, they would have the opportunity to speak to children, staff members, and board members. Children would have the opportunity to

speak to the care commission inspectors individually, although in all seriousness some of the inspectors were a bit scared of some of the children.

219. We were always provided with written feedback from the inspectors. We got verbal feedback first, then a written report which was in the public domain, because they were public inspections.

220. There was also a body called the host authority. For independent, charitable organisations located within a particular geographic area, notionally, we also had to report matters to the host authority. Renfrewshire Council did not want to be bothered with us. Their view was that as we were an independent organisation, they had no authority over us.

221. My understanding was that there was never any legal status attached to the host authority, but that it had been an administrative arrangement between councils, possibly via COSLA. Renfrewshire Council objected to dealing with us because they had both The Good Shepherd Centre in Bishopton, and Kibble, within twelve miles. They felt that a disproportionate amount of their staff time would be taken up in checking us.

222. Other than the Social Work Inspectorate of Scotland, SWIS, I do not think there was any other independent monitoring of Kibble. We tried to make the place as open and permeable as possible. I would hope that hundreds of people would say that they were in and out of Kibble all the time.

Concerns raised by independent inspections

223. Generally, the inspections were on the good side. I do not think we ever failed an inspection. There were always improvements suggested. Some suggestions we absolutely agreed with, some we were more hesitant about. We tried to see it as part of continuous improvement. It gave us a chance for someone to have an objective look at the organisation. I was younger when I was at Kibble, and a bit more strident

about some matters with the care inspections. If I did not agree with a finding, I would have defended our position. But these findings tended to be about administrative arrangements, never about anything from a child protection point of view.

224. If there was anything raised about child protection, I hope that the records would wholly corroborate me saying that we would absolutely be responsive to it. We might sometimes disagree on the tactics. In one instance that related to removing staff, we felt that the Care Commission were giving us advice that, as employers, we could not follow in the way they suggested. From an employment perspective we would not have been able to justify saying that we had followed a proper process.

225. There was one occasion where it seemed to us that the Care Commission were saying that as soon as an allegation was made, that the member of staff should be removed from the unit. In a place like Kibble, if we did that, there would never be any consistency of staff in the unit. We fought against that kind of thing.

226. I am sure that there would have been concerns raised about discipline or the treatment of children, but I cannot recall specific incidents. It would depend on the particular care inspector. Some inspectors liked to play their individual hand. I can remember once an inspector told me, "There is no letter of the law, it is the spirit." I asked how do we know what the spirit is? He replied, "I interpret the spirit." That was not helpful. We were trying to run a residential school, and that kind of comment I bristled against.

227. Generally, I think that we had good, but appropriate, relations with the inspectors. Even those that quite respected what we were doing challenged us, as they should have. Overall, I think the Care Commission gave us good reports, and you could go online and see that the reports were consistently good.

Record-keeping

228. Each child had their own personal file at Kibble. Everything in the sanction log should have been transferred over to their file. We never quite achieved a digital transfer in my time. I do not know if that has been achieved now.

229. What was in the daily log, which was the centralised record, should only have been very brief. The details of the causes of an issue and any sanction should have been in the child's record.

Investigations into abuse – personal involvement

230. I cannot recall any instance of a child coming directly to me to report a complaint about another child, a staff member, or a family member causing abuse. I was regularly button-holed by children, but that tended to be about issues such as pocket money, or what channels they could get on their televisions.

231. I never tried to be the trusted adult for children at Kibble, I never felt that I should. I fulfilled that purpose in previous roles, but not at Kibble.

Investigations into abuse – general

232. I cannot recall a definition of abuse being defined in a process at Kibble, but it was a constant topic of discussion in training. Psychological abuse was as much a concern as the issue of physical abuse, as was the abuse of power. The reporting of abuse policies were all defined, but not the term abuse. There would have been examples given of the reporting process in the event of specific instances of abuse. But it was absolutely the case that staff would have training on the different forms of abuse. It was part of the recruitment process, and it was part of the month-long induction training. It was definitely part of the curriculum. Staff would learn about that in their Higher National Certificate training, as well as by other means. It would be a subject that came up in Vocational Qualification assignments.

233. The procedures for reporting any abuse of a child would all have been contained within the procedure training. It evolved over time. Who you had to notify changed over time, but we tried to make sure that nothing remained within Kibble if an allegation of abuse

was made. Everything had to be reported out, and we let people know. That was not always well-received.

234. It was not always the case that social workers and field teams wanted to know about allegations of abuse, because they saw it as more work for themselves. If it was an allegation which was internal, they would not have to do anything. If it was external, they would have to do a child abuse investigation. To be clear, we did not want any investigations at Kibble to be internal. We did not feel that it was appropriate to be investigating ourselves. Remember the type of children we were dealing with, they were not a group of young people that were eliciting a great degree of sympathy in their own communities. I do not know how many times I was told that someone would say that they would pay anything for us to take a child and get them out of a certain local authority area.

235. There was a written policy that staff had to follow if a child made an allegation. There was also a designated child protection officer. There was a process that everyone knew to follow, and the child protection officer was meant to work outwith the hierarchical structure. They had a huge amount of freedom. We picked people who could be their own person for that role.

236. I think that the role of child protection officer and the associated reporting practice did work, because matters were reported, both internally and externally. It was certainly better than the days of not having a child protection officer.

237. As far as staff wishing to report child protection matters, there was an internal process and a whistleblower process. Both of these were in place from the early stages. The whistleblower process was there if staff felt their concerns were not being dealt with. Through that system, there was a direct line to the board. It was also made clear to staff that they could phone external agencies, like the Care Commission.

238. Internally the process encouraged staff to report matters of concern through the line management process, or directly to senior staff.

239. If there was any police investigation where a young person had made a complaint, the social work department were always notified. Sometimes we had joint investigations, sometimes they were separate. If a child had been placed with us from Highland Region, the social work investigation would go on up there.

240. There must have been occasions where there was a disagreement between what a local authority thought should be done about a complaint and what we thought should be done. I remember there was a situation like that with Glasgow Council, although I cannot recall the details of the case. There must have been more than just that one instance of disagreement, but I cannot recall any more of them. These would have been in relation to minor complaints, such as a young person being allowed to go home or not. If there was a complaint about an allegation of abuse, that would be much more high profile.

241. If there was disagreement between Kibble and the relevant social work department about the treatment of a child where there was an allegation of abuse, the social work department could refer the matter to the Care Commission, or they could remove the child from Kibble. I cannot recall an instance of that happening, but it is almost inevitable that it did over the period of time I was at Kibble.

242. If we then went on to take action against a member of staff, from an employment law point of view, that could not then involve any external body. There was a move from professional practice into employment law.

Reports of abuse and civil claims

243. I attended a few employment tribunals in my time at Kibble, as a result of staff being dismissed. Some we won and some we lost. I can recall one case where the employment tribunal wanted reinstatement of the employee and we refused, so we had to pay a financial settlement. That was not an allegation of abuse, it was an allegation of unprofessional conduct on the premises with another staff member.

244. There was a case which involved the theft of a high-risk child's confidential records. The confidential information ended up with the Sunday Mail. We took action against who we believed was responsible, but we were told that the information we had did not meet the required burden of proof for a tribunal case. It was another instance of us saying that we were not changing our position, the member of staff would not be coming back. We could not prove a criminal case, but that was not uncommon.

Police investigations/ criminal proceedings

245. There were pretty regular police investigations at Kibble. There was one particular case that I can recall in my time at Kibble which we felt constituted grooming, and that was reported to the police. The member of staff was charged, and I understand he was convicted at court, and I think he was admonished.

246. We had an investigation at Kibble and dismissed the member of staff. I cannot remember the name of the member of staff involved. I do not think I was involved in that investigation, because he did not appeal his dismissal.

247. Other than the above case, I cannot recall any other police investigations in relation to allegations of abuse at Kibble resulting in any criminal convictions of staff, for abuse. However, given the number of people employed at Kibble over the years, and the passage of time, I would stand corrected if there were records showing otherwise.

248. The case referred to above came to my attention because the member of staff concerned was taking young people out of Kibble out-with his working hours. He was taking them out on his own, and that was not permitted. That was the reason that it was brought to my attention. This was approximately twenty years ago, but my recollection is the staff member had taken a child back to his flat. The child said that nothing had happened, but we involved the police and the police charged him. I know it went to court and I think he was admonished. I did not have any personal dealings with that court case.

249. Staff were allowed to take children out of Kibble on their own if it was approved. This might be for outings that were on a one-on-one basis. There were also sporting events. These all had to be recorded and had to be approved beforehand either by the unit manager, or the duty manager.

250. It was also permitted for a staff member to take a child out of Kibble to the staff member's home residence. That had to be approved by the field team, approved internally by Kibble, and the family in the home to be visited and had to be police-checked. The practice of taking an individual child to the home of a staff member usually occurred where the young person had no family. For example, it might happen at Christmas.

251. That practice became less common as time went on, for various reasons. Partly, people began to get nervous about being accused of something. There were also good reasons why it became less common, such as the fact that there was much more of an attempt to keep children attached to whatever family they had. Also, the residential units were becoming more homely. Changing dynamics just made the practice different.

Other Staff

252. I understand that there are some members of staff from Kibble that you wish to ask me about and I am happy to give any information that I can.

IGK

253. IGK started off as a residential worker. I think he started work at Kibble just before me. He mostly worked in day services. He was then promoted to senior staff. I think he was still at Kibble at the time I left. He was a very long serving member of staff. Over the period I would say that I knew him well. I knew him as well as any other member of staff. I saw IGK interact with children all the time. I would say his relationship with the children was excellent. He was a very popular staff member with

the young people. He was a qualified social worker. If I remember him for anything, it would be that he was always putting the children first, sometimes to an unrealistic extent. For example, he would often advocate very strongly with other staff, on behalf of young people.

254. I do not think I ever saw IGK [redacted] discipline children. I definitely did not see, or hear about, IGK [redacted] ever abusing children.

HOS [redacted]

255. I take it that is a nickname because he was either very tall, or very short. I have no idea who that would be.

KDH [redacted]

256. The reason I remember KDH [redacted] is that he came as an HNC student on placement in my first year at Kibble. He then worked his way up through the organisation. He was very involved in the football fraternity and did a huge amount of work with children in relation to sports. He would have come across as a very decent and qualified guy.

257. I do not think I ever saw KDH [redacted] discipline children. I definitely did not see or hear about, KDH [redacted] ever abusing children.

zGNS [redacted]

258. I vaguely remember that name, I think from the late 1990's, but I could not tell you much about him.

KGK [redacted]

259. KGK [redacted] started off as our domestic superintendent, when there was such a thing in the organisation, but she then moved over into the care staff side. Latterly, she

worked night shifts but had long periods of ill-health. The last I heard, she was chronically unwell. She was popular amongst the children and quite kindly.

260. I do not think I ever saw KGK [redacted] discipline children. I definitely did not see, or hear about, KGK [redacted] ever abusing children.

KFE [redacted]

261. I remember KFE [redacted], KFE [redacted] played junior football for the [redacted] team. He was one of a small group who came in from the football fraternity. I think KFE [redacted] was still at Kibble when I left. I think he may have been a unit manager. He loved sports. He did a lot of stuff with football for the children.

262. I do not think I ever saw KFE [redacted] discipline children. I definitely did not see, or hear about, KFE [redacted] ever abusing children.

KFD [redacted]

263. I remember KFD [redacted] from the first decade of the 2000's. I can just remember him as a day care worker. I do not remember anything negative about him. He was not a larger than life character, I just remember him as being run of the mill, but I do not mean that in a negative way. I do not remember him for any adverse reasons.

264. I do not think I ever saw KFD [redacted] discipline children. I definitely did not see, or hear about, KFD [redacted] ever abusing children.

KDK [redacted]

265. I have got no idea who this is referring to.

KFH [redacted]

266. I know that name, vaguely, but I do not think I could put a face to that name.

Convictions

267. I have no criminal convictions.

Leaving Kibble

268. In 2016 I intimated to the board that I would be leaving Kibble. There was no one reason, but I had done almost forty years at the front line. Both my elderly parents were alive, but very precarious. They lived up north. The last of my children was about to leave the nest, although we still had my mother-in-law with us. Family pressures were such that we thought, "Now's the time." We had [redacted] at Kibble. We had moved on all the other senior staff, and I was the last of the old guard to go. It was a [redacted]. The board agreed a six-month [redacted] with [redacted] SNR [redacted], with the idea that I would go at the end of that.

269. SNR [redacted] who [redacted]. He is still at Kibble. He was brought in the year before he [redacted], in [redacted]. There were a few contenders for the job of SNR [redacted]. I had been at Kibble for a long time, and in places where people stay a long time there can be problems [redacted]. The board did take a long time about it. I was involved in some of that but not all, quite correctly. I had nothing to do with the interview of [redacted]. It was a planned move, with people who were experienced and qualified in the sector. It did go to external advertising, but the response rate was very poor.

270. I left Kibble at the end of March 2017 after 24 years.

Steps that could be imposed to reduce the risk of child abuse or steps that could be taken to protect children in care

271. Childcare had been my whole working life, so that question is something that I reflect on from time to time. You not only ask how can it be better going forward, but you also ask yourself what could I have done differently? As I have said, we were trying to modernise residential childcare, trying to be transparent, and bring in new things. Obviously, it did not happen properly all the time, but in that type of work there are many hair's breadth decisions, and situations that are very volatile.

272. I do not think there are any easy answers, but I do know from experience that there are loads of steps you can take to reduce things. I think that good systems do make a difference, but you cannot take the humanity out of the systems either. How do you balance these? The reality is that we want less young people in care, not more. The real answer is to try and do a lot more to keep children in families, but I know that is too trite an answer because I know from my own personal experience that that does not happen all the time.

Other information

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

Signed..... KTN [redacted] .....

Dated..... 25 November 2024 .....