Scottish Child Abuse Inquiry

Witness Statement of

KTS [redacted]

Support person present: No

1. My name is KTS [redacted] My date of birth is [redacted] 1968. My contact details are known to the Inquiry.

2. In 2018 I saw an email that had been circulated at my work by Michelle Miller the chief social worker for Edinburgh. She was asking anyone who had any information about child abuse to come forward to the Scottish Child Abuse Inquiry. It was encouraging staff to come forward and as I had already provided a statement to the police I decided to contact the Inquiry.

Qualifications / experience

3. Originally, between 1986 and 1991 I trained as a teacher, I was a home economics teacher. I worked in the borders teaching and then moved to more social work orientated work, in the community, with adults who had learning difficulties. Then I ran a money advice and debt counselling project. That had urban aid funding and lasted for about four years. I then had to look for something else.

4. I saw adverts for Residential Care Officers (RCO's) in Edinburgh and thought it kind of married up with what I'd been doing. It was still working with young people but with a more social work vein, a combination of social work and teaching, which I saw as a good opportunity.

5. I applied for the post and was accepted. I didn't have any specific formal child care or social work qualifications but, at that point in time, because I was a qualified

teacher, I was deemed to be a qualified RCO. Therefore, my training was only a four day recruitment process. That involved role play, written exercises, videos and discussions. I think it was to work out where peoples' values were but also to let people know what was expected of them in the role.

6. It's not the same now, but at that point, you had to work as a locum worker, you didn't go straight into a job. So, I worked a few shifts at Northfield Young People's Centre and a few shifts at Moredun Young People's Centre, both in Edinburgh. I was then offered two weeks at St. Katharine's Secure Unit, which went okay. They then offered me a six month contract as a locum, which I accepted. I moved to Edinburgh in May 1999, and the six month contract I got was from September 1999 to February 2000.

St. Katharine's Unit, Edinburgh – August 1999 to February 2000

Work arrangements / staffing

7. St. Katharine's is the name of the complex. The Guthrie unit is a secure unit within the main building. In the main building there was the secure complex, the education wing and office space. Then there were two additional buildings within the complex, which were close support and were not secure.

8. [LUZ] was [redacted], he was [SNR] of St. Katharine's complex. Then there was a group of senior staff who over saw the running of the units.

9. When I started at St. Katharine's there wasn't much of a handover but because I was a locum Residential Care Officer (RCO) I had a supervisor, [KEI]. Carol Mentiplay was running the recruitment centre then and to qualify as a proper RCO I had to fulfil a number of competencies.

10. I have shown the Inquiry all the appropriate documentation that relates to these competencies and I can make them available if necessary (ref. 'File 1'). They relate

to oral and written communications, professional values, assessing and responding to needs, commitment to learning and professional development, maintaining professional boundaries, working as part of a team, relationships with others and managing conflict and stress.

11. During the six months I was there, it was my responsibility to write up these competency forms to evidence my performance in those specific areas. I did manage to complete them all while I was there, so I suppose there was supervision. I also met with Carol Mentiplay to discuss my performance.

12. If there was ever an incident, or something happened and an alarm was pulled, it would register on the computer system which was in the staff work station in Guthrie. It would normally be for an incident in Guthrie, but it could be for any of the three buildings. So that would tell you where to go and it could be any staff from any building that might respond to such an alarm. Staff did tend to be based in one place but they could equally be moved between the buildings.

13. The staffing worked on a rota and when I started my six month contract I was on a particular team within Guthrie. There were two or three different day teams and a night staff team. The nightshift tended to be the same permanent staff all the time but the day staff alternated between earlies and lates. We then had alternate long and short weekends. The staffing was set up on that basis for the entire time I was at St. Katharine's.

14. We did have handovers, one in the morning, one during the day, about 2.30 pm, which was more thorough, and one at night. The residential day staff had a better idea about what had been going on with the children hence a more thorough handover in the afternoon for the late shift.

15. The evening handover was generally a simplified version of the afternoon one and telling us that the children were all in bed. During the nightshift the staff are awake but there would be an additional RCO, who would sleep in the staff bedroom, but be available should anything happen through the night.

16. The team I worked on had two males, KEL [redacted] and IDJ [redacted], and two females, Vicky Grant and myself.

17. There was about six to eight residents at St. Katharine's, boys and girls, aged between thirteen and sixteen. They were there for a variety of reasons but they all had to be under a secure order which, I believe comes from a children's hearing. The child or young person had to be a serious risk to themselves or others.

18. The children had individual rooms which could be locked. The rooms were en suite, although the bathroom area could also be locked.

19. If you were on early duties, part of your role would be getting the children up, making sure they got ready and came through for breakfast. That would be about eight o'clock, possibly later at weekends.

20. Within the Guthrie unit you can only open one door at a time, so if one door is open in the main corridor, you can't open the door at the other end of the corridor. The main corridor had two bedrooms, a staff sleeping room and a visiting room.

21. Then you would go through to the main area where there was some solid fixed benches, where we all sat at mealtimes. There was access to the kitchen behind that and there was a tv room off that main area as well. There were sofas in there and that room was never locked. Generally speaking they were the two communal areas.

22. Generally speaking all the children had to be up and at breakfast. We would all eat together. The food was actually alright, it was good. The children may not want to be there but they would be, there wasn't really an option.

23. In fact, some staff would take the duvets off the children while they were lying in their beds or take everything off their beds and take the mattress away, to get them up in the morning. That was common practice, it wasn't unusual to come in to work and find all the contents of someone's room in the hallway.

24. I primarily worked with the same two guys, KEL [redacted] and IDJ [redacted], and occasionally they would take duvets or a mattress off the children beds in the mornings and tell the children to get up and get ready.

25. An official reason for doing that may be because someone had been behaving in a way somebody didn't like, and it was being done as a punishment. On occasion it may have been as a safety precaution, had someone been threatening suicide, and everything was being removed to prevent them from harming themselves, but, in my opinion, it was just sheer bloody-mindedness' by the male staff.

26. In my opinion, even the procedure of removing everything from the room to prevent suicide, and then leaving the child in the room, was not an acceptable practice, let alone just to get them up in the morning. However, that is what happened.

27. It was a very male orientated, very macho set up at Guthrie's and women weren't really thought that highly of, not within the unit.

28. The children did have chores at the weekend, hoovering and tidying their rooms. Then they had education during the week. There was an education wing with separate teaching staff, so education was available, of a sort. I feel, being a teacher, I'm qualified to say that, because the education wasn't great.

29. There was a central, outdoor, open area, at the education wing where people would go to smoke. Even though you can't buy cigarettes until you were aged sixteen the children were allowed to have cigarettes and to smoke. There would be smoking breaks for children in that secure area.

30. The children did have some leisure time. Their days basically consisted of getting up, having breakfast, education, back into the unit for lunch and then back to education in the afternoon. Then they would have a little bit of down time to themselves. They also had their cigarette breaks throughout the day.

31. After education, in the evening, they could watch TV, rent DVDs or videos, there was a gym, or perhaps they had things that needed to be done that were part of their Care Plan. Maybe they had family visits or there could be a number of things happening. They would get to go out clothes shopping, have visitors come in and see them, there were different things.

32. Every child had a Care Plan which was child specific and identified particular needs and intended outcomes for that child. It set objectives for work with the child, their family and the carers in relation to the child's developmental needs. Things like health, education, emotional and behavioural development, family and social relationships and self-care skills.

33. The children got an allowance, pocket money, that was given to each child. I'm not sure where that comes from but it's an allowance, possibly through the social work and the council. I think the young people saw it as an entitlement and a lot of the staff, perhaps thought it wasn't deserved. So, sometimes the shopping trips didn't happen or the children didn't get what they wanted.

34. The staff could decide not to give a young person pocket money, perhaps as a form of punishment for bad behaviour. That could then be used by the staff member to provoke a toy-fight incident and tell them they weren't getting their pocket money.

Child welfare

35. Each child did have an allocated social worker from outwith the unit, who was involved with the child, but, I can't remember exactly how much they were involved. There was also a Children's Rights Officer (CRO) that would come to the unit or that a child could ask to see.

36. Someone couldn't just turn up and visit a child, it did have to be arranged. I think the social work managed that. The children had their Care Plans and if it was in the plan that there were no visits then there were no visits. Perhaps their allocated social worker would visit, but they might not, and residential staff always had the final word,

so they could always say no. SNR wasn't keen on having anybody from outwith the centre involved in anything inside the unit.

37. The Care Plan was compiled by a combination of the social worker that was allocated to the child and the residential staff. There were planning meetings but the care plans were weighted by the residential staff.

38. One concern of mine was that some staff gave children cigarettes. That was as a gift and in my view that was a potential grooming tool. I'm referring to actual packets of cigarettes here, not just the odd single cigarette.

39. When I first started at St. Katharine's there was a lad, KSL that the staff all called LUZ 's golden child. LUZ who was SNR would take him up to his office, out the centre or give him cigarettes. KSL seemed to get different treatment from other children. I wasn't aware of anything untoward happening, there wasn't any evidence of that, but that was totally inappropriate and wasn't part of LUZ role as SNR

40. Many staff, KEM , IDJ and KEL spoke of LUZ taking children to his own house. That is not something I ever saw but it was spoken of and when you look at the training we receive as RCO's you know that is not a good idea. You could be setting yourself up and it may lead to people questioning what's happening. The suspicion was that there was some kind of abuse happening.

41. I raised my concerns with LUZ , prior to submitting anything formal and he very much said that he thought anything within the context of the relationship was appropriate, even sexual behaviour. He was talking about sexual attraction being okay between a child and a member of staff.

42. On one occasion I went to see him with Carol Mentiplay, a supervisor, and he wasn't interested in what I had to say. I was expressing my concerns about staff massaging children. Staff were massaging children's shoulders, sometimes without even asking their permission, often even at the request of the child (ref. 'Some concerns that I

have' notes from KTS [redacted] and 'Background Notes re KTS [redacted] from Carol Mentiplay).

43. I thought this behaviour was completely inappropriate, and we weren't trained to do that. The outcome of that meeting was that it was okay to do that if you felt okay doing that. I still don't think that's appropriate. KEL [redacted] and KEH [redacted] both massaged children, without being asked.

44. I was consistently told at such meetings that there would be consequences for me by raising concerns and that I wasn't a suitable person to work in social work. That made me feel very unsafe, I don't know who knows who and who's involved with who, so it makes it very difficult to express an opinion as a City of Edinburgh Council employee.

45. LUZ [redacted] spoke to me later on and told me he was unhappy I had brought Carol Mentiplay to the meeting because she was somebody who was outwith the unit. He very much viewed it as his unit.

46. I wrote my concerns up and raised them at team meetings and you will see them on the competency forms I have given the Inquiry. The massage incident for example, I wrote it up at the time. (ref. 'Evidence Number 25')

47. LUZ [redacted] also wrote a report up on my competencies. The Inquiry have that as well. (ref. 'Report on KTS [redacted] Progress' by LUZ [redacted] dated 23.2.00). He described me as being 'concrete.' I take from that, he means I follow the procedures that were in place and not wanting to physically abuse children, but that is what I witnessed in that unit. Children were being physically and emotionally abused and not treated with any dignity or respect. In my opinion that unit wasn't a safe place for a child to be.

48. He also stated that I can sometimes have a 'critical approach to colleagues practice' and that I have 'taken some non-contextualised concerns beyond the individual with who they are located and beyond established line management channels'. He is

purely commenting on me speaking to Carol Mentiplay, but she had to be there, that was part of her role, to monitor the competencies. He didn't know I was a whistle-blower and that my identity was protected, when he wrote up those comments.

49. He goes on to say that I 'repeated my approach despite being appraised of appropriate ways to raise practice issues'. That may not sound like a lot but to me that shows that he did want everything in that unit and that was very dangerous. He didn't want any outside input.

50. There are complaint forms available for the young people but they are not readily available and staff are hesitant to hand them out. There was also the Children's Rights Officer (CRO) but if a child decided to speak to the CRO negative things are going to happen because the CRO has to speak to someone else within the unit. So, the children wouldn't report things, they were afraid to do so, they were afraid of the consequences.

Disciplining of children

51. If there was a situation where a young person genuinely misbehaved and it was of a minor nature then the first course of action would be to verbally address it. If it was felt to be more serious then pocket money could be taken away or things might be taken out their rooms.

52. If they were due to be going out, perhaps to the cinema as part of their Care Plan then they might not get to go. Depending on the nature of what the young person had done, it could always lead to a physical restraint.

53. I think use of restraints was supposed to be recorded. Certainly if there were physical assaults on staff that was meant to be recorded. Sometimes those records got ripped up though, sometimes they were left and sometimes nothing got done at all. There was definitely a serious incident or injury form.

54. There was some running away. I remember one laddie, KTB [redacted] who was a little lad, managed to prop a gym bench up against a very high wall and get over it. That was spectacular but it was usually children absconding when they had been out visiting their families. There are differing stages of secure within a secure unit. It was never something that was meant to last forever, so a child could have been visiting family and absconded because they didn't want to come back.

55. They could also run off when you're out with them, maybe just going to the petrol garage to spend their pocket money. There's not a lot you can do if you're in charge of three children and one decides they're leaving. It was difficult to get out of the unit itself, as it was secure, like a prison, so absconding from within the actual unit was quite rare.

56. The punishment would usually be that they were put in their room for an extended period of time, on their return to the unit. It could depend on who it was and the circumstances.

57. Bedwetting was dealt with unkindly. There is night staff, one in each building, so perhaps three staff. Children were locked in their rooms but the rooms were en suite so a toilet was available. If they wet the bed they could use the buzzer to alert staff, although I don't know what kind of response the night staff would have given to that. You would hope they'd be given clean sheets.

58. For me, some of the night staff weren't particularly nice people. I don't know how bed wetting was dealt with exactly but, on occasion, I went in, in the morning and there were no sheets and the child was sleeping on the floor, with no bedding in the room.

Inspections

59. There were inspections or checks at the unit but they were never ad hoc, you always knew when people were coming. Staff would tidy up paperwork, puts things in place and have the unit looking the way it should look. Staff who would tow the LUZ [redacted] line would then speak to the inspection people. I was never involved in any of that.

60. I remember on one occasion, prior to an inspection, it became apparent that only two of the six young people staying at St. Katharine's had Care Plans. Every resident should have a Care Plan. A member of staff then had to fill in the four outstanding programmes the day before the inspection.

61. I remember it was announced after the inspection that they only just got away with it. Much of the information had to be made up. It was all done last minute, just the day before an inspection, when it was realised.

Abuse at St. Katharine's

62. One of the main things that concerned me at St. Katharine's, which I attempted to address, was male staff entering into what they would call 'toy-fighting' with young people. About 99% of those toy fights ended up with young people being restrained on the floor, and undoubtedly injured. That restraint could involve four or five adults, primarily men.

63. Those toy fights could start in a residents room, in education or maybe when a young person was just sitting watching television. I remember on one occasion KEH KEH who worked at the unit, came in and started poking at one of the lads, PCX PCX He was poking at PCX arm and flicking his head, just looking for a response.

64. PCX then reacted and the pair of them got into, what I would consider, a physical fight. That was most definitely initiated by the worker and not the young person. KEH was then over powered, had to pull the alarm and lots of men came and restrained PCX PCX was out of control, but only because of KEH before that PCX had been fine, sitting watching tv.

65. That was a daily occurrence, male workers provoking a reaction out of the residents, which resulted in the restraining of a young person on the floor. That frequently led to

injuries, primarily carpet burns, on the young person. Once things had calmed down the young person would then be taken and shut in their room.

66. If the young person didn't calm down and started throwing things about in their room, then the team that had just dealt with them, would go back in and take everything out the young person room. That was on the basis that the staff were protecting the property.

67. What makes that behaviour by staff all the worse is that these are children who have, primarily, already experienced terrible traumas in their life. They may have been in care, had violent parents, possibly seen domestic abuse and/or drug abuse within the family setting.

68. Just looking at PCX [redacted] he was about fourteen, all his siblings had been in care at some stage and he was known to self-harm. PCX [redacted] was provoked on a daily basis, then he would get locked in his room and smash things up.

69. He was once provoked and pushed around and ended up locked in his room. Then he [redacted] slashed both his wrists [redacted]. In my view that was the interaction of the staff that caused that, and the staff would say it was just toy fighting, it was just a laugh, a bit of fun. My view was always that it was not a laugh and it was not alright, and I've never wavered from that.

70. KEH [redacted] was a senior member of staff, but there were others who behaved in exactly the same manner. Kevin Glancy, was another, a senior social worker, who was in an open unit but responded to the alarms and assisted with the restraints. He was convicted of having large quantities of pornographic images on his computer in 2008.

71. I should say that Vicky Grant and I hadn't been trained in CALM (Crisis and Aggression, Limitation and Management) although sometimes we still ended up involved in restraining residents. CALM is a restraint technique which is used to manage children in difficult situations, without causing harm to the child. There are

specific ways in which that should be carried out and there is a specific training course that people should go on.

72. I was CALM trained some time later, in another role, as a RCO, after I had left St. Katharine's. I was never trained in it at St. Katharine's and, technically, you shouldn't be involved in any restraining unless you've received the training. A decision had been made at the unit, that you could be advised what to do by a member of staff who had the training, if no one else was available. That was just the culture within the unit. I don't know who specifically made that decision.

73. I'm sure it was KEL who showed me particular things and told me things, but I was never formally trained in CALM at St. Katharine's.

74. Children would be sent to their rooms as a punishment. That could be for not eating their breakfast, but there was no food in their rooms. If the staff member that put them there decided they weren't getting out then they could go without their lunch as well. That could just be because the staff member didn't like them or perhaps because a senior member of staff had said to just leave them in their room. That wasn't frequent but it did happen, maybe every few weeks.

75. Primarily the same staff were doing those type of things, that or the same senior staff were instructing them not to let the children out their rooms. So that was IDJ IDJ and KEL on my shift and the senior staff were KEH and LUZ LUZ. There's many a time, I suggested to those particular senior staff that we needed to get a child out their rooms and off to education but I was told no, and that was that.

76. Then later on, when I started raising some real concerns, I was getting told that if I started doing that I'd never work in social work. So it wasn't just the young people that were being affected, it was staff as well.

77. There were trained teaching staff in the education unit and it was our job as RCO's to take the children round there, to be taught. There were classes but I don't ever

remember any children being in there for long. If something happened, and a child misbehaved, then the teaching staff would want us to come and take the child away. That could be threatening to burn the school down with a Bunsen burner or just throwing a rubber.

78. There was an alarm in the class and the teacher would pull the alarm. We would come and take the child away, and that would usually end up with a physical altercation and a child being restrained. The child would then be taken to their room. That could be five or six guys picking them up and carrying them.

79. That was just about always the case, I would say that only about 5% of the time the staff sat down and talked to the children, and actually engaged. It was always about going in and pulling somebody out the class. That could be a thirteen year old girl, screaming and shouting and writhing on the floor with five or six adult men, trying to restrain her.

80. A staff member, KEJ [redacted] once ended up with a broken arm from a restraint he was attempting. Children ended up with carpet burns down their faces, down their backs and on their arms. They were never given any treatment for the carpet burns on their faces, which came from being held face down into the carpet.

81. I don't remember ever seeing a doctor at St. Katharine's, but that's not to say it didn't happen. I did take a girl to the doctor once and there was some sort of health assessment when the young people were admitted. I can't remember the detail about that but there was a medical and a search of every child that was admitted. That led to an investigation by Edinburgh Council.

82. It relates to a woman who came forward to the council and complained about the way she was treated at St. Katherine's. She was a resident there. Her name wasn't released but she received an apology from Edinburgh Council. I don't know the specifics but it was in the papers and will be public knowledge.

83. All their belongings were searched, primarily for drugs, and then there was, more or less, a strip search procedure. The child would be asked to go into the bathroom off their room, take off all their clothes and throw them out to the staff. They then wrapped a towel around themselves, came out and jumped up and down before going back into the bathroom. Then they handed out the towel before dressing again. Staff would search the bathroom before and after.

84. I believe it should have been males searching males and females searching females but that wasn't always the case. That wasn't because females weren't available it was because the men said they were doing it. Likewise females would manage the search of males in the manner I have just described. You never saw the children naked, at least I didn't, but that was the system and it was very humiliating.

85. I think there was a written procedure at the time but it wasn't followed, and it was residential staff that were doing it, not medically trained staff.

86. I mentioned PCX [redacted] if he had self-harmed then he would be taken to the hospital by two staff. He would [redacted] once he was back at the unit. Staff, not me, would then make a decision that he didn't need to be taken back to the hospital again.

87. If children said they had an injury or weren't well or whatever they were often told to shut up because there was nothing wrong with them. They were simply seen as being difficult, so they'd be taken to their room.

88. I can think of children being prescribed medication by the doctor and the unit staff then telling the child they weren't getting the medication or that they didn't need it. Staff could make decisions like that. It could be because the young person had kicked off or it could be because the staff just decided they weren't getting it.

89. I'm sure we kept the prescribed medication in our office and there were sheets to sign if staff were giving out medication. I don't ever recall such behaviour resulting in anything drastic happening but that was completely inappropriate.

90. One of the things I had completely forgotten about was that staff would bend children's fingers back until the children were begging for the staff to let go, sometimes lying on the floor. That really could be just because the staff felt like it. Part of the toy fighting thing I was talking about.

91. Three people who were primarily responsible for that kind of behaviour were KEH KEH , KEM and KEL all of whom I worked with.

92. I didn't witness this but there was talk amongst the staff at St. Katharine's that young people were being provided street drugs by certain staff members. Primarily cannabis, but as it was rumours, I didn't give it much weight at the time.

93. Since then I have learnt, as it was in the press, that KZB who was a staff member at St. Katharine's when I was there, and one who bent fingers and became very involved in restraints, was convicted for producing cocaine. He received a custodial sentence. It made me wonder if the rumours, about providing drugs, were perhaps true but I don't know.

94. There was certainly signs, at St. Katharine's, that children were under the influence of drugs. KTB who I mentioned earlier, I would say he was often under the influence of drugs. He had dilated pupils and was often in a slightly 'higher' mood.

95. I have been in social work since about 1999 and I now have over twelve years' experience working as a criminal justice social worker. I encounter people who are under the influence of drugs on almost a daily basis, and I would say there was often a suspicion that children were taking illegal drugs within St. Katharine's.

96. Other staff from St. Katharine's, but not from our secure unit, would need to come into our unit for food. The kitchen was in our unit but there could be other reasons, possibly an alarm going off or maybe for a meeting. Alternatively, other staff might

come in during a quiet spell and openly state that they were over to wind up the Guthrie residents.

97. Another specific incident I remember involved KEO who was a member of staff that worked primarily in the open units. He came into the Guthrie unit, grabbed a child, and threw him on the floor, for no apparent reason.

98. KEO threw to the ground and hit his head on the concrete floor. appeared to have some kind of seizure on the floor, he was certainly moving frantically and involuntary. came round fairly quickly but there was no medical intervention with that incident. I was told it was just toy-fighting.

99. , was a young person who stayed at St. Katharine's. and a RCO, Vicky Grant, both told me of an incident where KEI a member of staff, had pinned PCX a young person, up against the wall by the throat. I raised my concerns but was told by KEI that it was a misunderstanding and that he was not holding PCX by the throat, but in a different position.

100. KEI spoke with PCX and, in my opinion, talked him around. That was a typical way of dealing with complaints, so the children weren't interested in talking because they knew nothing ever got done about it. I was present when KEI was questioned about that behaviour. He said his arm was across PCX chest and denied it all.

101. I didn't see that specific incident but I saw KEI holding children up against the wall by the throat. Their feet would be off the ground, up against a wall and he would say it was the only way he could restrain them. KEI still works at St. Katharine's.

102. There was another incident I saw where KEH came into the main area and ran over to PCX and kicked him on the backside. PCX was just standing there, not doing anything inappropriate and KEH kicked him for no reason at all. That was another occasion that resulted in a restraint procedure.

103. There was so much inappropriate behaviour that staff were participating in. It was not deemed inappropriate to grab a child and twist their nose until it was bright red and possibly bleeding. It was not deemed inappropriate to grab a child's hand and bend their fingers back until they were pleading on the ground to be let go of. That happened throughout the time I was at St. Katharine's and after I had raised my concerns.

104. There was no concern shown for the child, the staff that carried out the abuse I'm talking about, enthused about it. It was used to control people but also for pleasure, I think the men that were responsible were happy, they were pleased about it. You would hear them saying 'did you see that carpet burn' or 'you missed a brilliant restraint this morning, you should have seen it'. It was that type of thing there was no concern for the child or focus on the child after what had happened.

105. I have named a few people and they were all responsible for unacceptable and inappropriate behaviour towards young people in St. Katharine's unit. There was KEH , KEI , KEO , who I spoke about and KEM , a big [redacted] guy who was very fond of grabbing noses.

106. Then there was [redacted] KEJ and KZB who I've also spoken about. The majority, I'd say as much as 90%, of the restraints I witnessed were provoked by staff, that was mostly the male staff that I've mentioned and it was mostly for entertainment and pleasure. I think the men were bored and it gave them something to talk about.

Whistleblowing

Whistleblowing procedures and investigation

107. I have shown the Inquiry a file of letters that were sent to me and records that I compiled relating to my concerns about the practices that were going on at St.

Katharine's. I then raised those concerns through the councils whistleblowing policy in February 2000 (ref. File 2).

108. I spoke to staff on many occasions when I saw what I thought was inappropriate behaviour. I did do that and there is no doubt that is why certain members of staff did not like or trust me. So I talked to people but that got me absolutely nowhere.

109. I went through all the appropriate channels within the unit. My line supervisor was KEI [redacted] but as one of the individuals who was behaving inappropriately, I couldn't speak to him. I therefore went to LUZ [redacted] who's report stated that I was appraised of appropriate ways to raise issues. Those appropriate ways were basically not to continue with what I was doing and to deal with it within the unit. So, I was getting nowhere.

110. As far as I could see, at the time, the only option for me was to use the whistle-blowing procedure. That was why I decided to go down that route and raise my concerns.

111. I had been at St. Katharine's for perhaps four or five months when I made the decision and I read up on the procedures. It was certainly readily available to me and it was a procedure you could do anonymously. My name was kept out of it. I also had several external conversations with Carol Mentiplay, who was in training, as part of the process.

112. As part of that procedure I met with Leslie McEwan, the director of Social Work and Duncan MacAulay the Head of Operations for the Social Work. We had a general discussion then I provided a statement and quite quickly I was moved away to the unit at Greendykes.

113. My understanding is that the council then carried out an investigation. I was asked further questions during that and met again with Leslie McEwan and Duncan MacAulay to get some feedback. I kept all the paperwork in connection with that and I've provided the Inquiry with that as well (ref. File 2).

114. I understand that LUZ left St Katherine's before he was asked to leave. [redacted] It's a question of mind-set, he sees there to be a different way of caring for children and seems to stand by what he said in relation to taking children home.

115. I know he recently stated publicly that he was not convinced of any of the sexual abuse allegations that have been raised against many public figures. He sees it as fictitious historical events that are being brought to the fore. That is the man who was [redacted] of the secure unit at St. Katharine's.

116. As a result of the investigation the social work department recognised there were some things that had to change and they would be addressed through staff supervision. LUZ left St. Katherine's during the investigation of my whistle blowing complaint.

Response to whistleblowing

117. I was fortunate enough to be able to move on to an RCO's post in the young person's centre at Greendykes in Edinburgh. That was all around about the time my six months was up and when the whistle-blowing procedures started.

118. I do sometimes think I should have tried to stay and fight it from the inside, but when I think on it, I couldn't have done that. I did everything that I could have done at the time. Very few people said or did anything, they just went with it.

119. I do know there was a woman who was at St. Katharine's before me who had raised concerns. In fact it's because of that I was called a plant, by other staff, for the first few months I was there. They thought I was there to follow up on her complaints after her departure.

120. I think I got dealt with well, I wasn't informed of the progress but at the end of it all I was asked to come back in, which I did with Carol Mentiplay. That was some time later, but overall I was satisfied with the whole process.

Personal impact of whistleblowing

121. I am aware this will all be public and my manager is aware of that but, as I have said, speaking up and raising concerns has, at times, made me feel unsafe. I have had counselling and psychological support to consider some of the issues. If it left me feeling like that, what has it done to some the young people who haven't had the same opportunity. Are they still thinking that was just toy fighting or that was just a bit of fun by the staff?

122. I was told my name would be kept out of it and, to be fair, I think it was, but I was not at all convinced about that, at the time, particularly with having been called a plant. As I said, the timing was fortunate though, as it was right at the end of my six month contract.

123. The whole process has definitely made me anxious. I know it's not my responsibility but I have done what I think is right. There's only a few people know I've done this, outside of senior management, but still, every time it comes up I think I could lose my job. I know I am the one who's standing up but it still has that impact on me.

124. There's also the fact that abuse still goes on. It's so upsetting every time you see a new case. What you're hearing about is the worker you're not hearing about the children. It might be one, two or three children have come forward but the likelihood is there are many more because there will always be children that haven't come forward.

125. Most of the children I've talked about actually thought it was a good laugh and everything was okay. They were told what to think though, that it was just toy-fighting and a laugh and not to complain. That's the environment that was created, a culture where people would not complain.

126. These are some of the most damaged children in our society, with some of the most difficult and demanding needs. They get put in St. Katharine's, a place where they will be further abused, and the staff just normalise it, which is appalling.

127. I don't think I'm properly over all this, it gets easier but every time I remember something it impacts on me and it's not a positive impact. I try and manage it all, otherwise it would become overwhelming. There's always something different that perhaps didn't strike you as awful the last time you looked at it.

128. I also still have to work with some of these people There are people named in those files, who I went to for advice, Robert Henderson, for example. I went to Robert for advice at St. Katharine's and was told by him to ignore it, he gave me a rubbish bit of advice.

129. I met him recently, at work, and he denied knowing me, but when I went through my evidence files with the police two years ago, there was his name, so he did know me. He has obviously been avoiding me, so that's the type of thing that's happening to me and that carries an impact.

130. Secondary Institutions - to be published later

131. Restraining young people does sometimes need to happen but at St. Katharine's it was always restrain first, ask questions later. There was no attempt to initially diffuse a situation. Secondary Institutions - to be published later

132. Secondary Institutions - to be published later

Police involvement

133. In relation to the issues I raised and the abuse I reported through the whistleblowing policy there was eventually police involvement. I was interviewed and provided a statement about two years ago now.

134. I know the police interviewed PCX [redacted] about his treatment but he thought it was acceptable, that's what he was always told, that it was toy-fighting and that it was all just a laugh. It's not acceptable but he's been conditioned, if you like, to think that it is acceptable. PCX [redacted] life was ruined in there over several years and I believe he's now in prison.

135. That whole system at St. Katharine's conditioned the children not to come forward. I suspect the people that have come forward were perhaps only involved for a shorter more specific period of time.

136. In relation to specific incidents there was, on more than one occasion, incidents where I was assaulted by a young person and had wanted to report it to the police. I reported physical assaults to LUZ [redacted] and recorded them myself, but he was not of the opinion reporting it to the police was something that should happen.

137. LUZ [redacted] felt it would make the relationship with the child worse. So he did not allow that. He made it very clear that if I wanted to have a job, it was not something I could do. I subsequently discovered, when working in other units, that it was common practice to report assaults on staff to the police.

138. A colleague of mine, KTV [redacted] also gave a statement to the police, that was about different behaviours that she saw. I think that was to do with a drill being held to a child's head, but I don't know all her concerns and we've not discussed anything. It was probably while LUZ [redacted] was [redacted] but I'm not sure.

139. There were quite a few documents the police were interested in from the files I provided.

Records

140. Records were sometimes maintained and recorded at St. Katharine's. It was a manual system we used not a specific system, like SWIFT, which the social services use now. There should have been recording of details going on all the time but this is an interesting issue because, as I said earlier, sometimes records just seemed to appear in time.

141. Alternatively, records could also disappear. There were documents I filled in, or knew had been filled in and then a few weeks later when you went looking for them, they weren't there anymore.

142. In my view records were never maintained accurately at St. Katharine's. For example, if a child was locked in their room and they weren't getting out, you were supposed to carry out a check every twenty minutes. That needed to be signed and should have been on a form which was filed away. Nobody ever checked and I used to get ridiculed by other staff for going up the corridors and carrying out the checks.

143. If something happened to a child, in my experience at St. Katharine's, the staff would have lied about the checks but that's my opinion only. There were policies in place and I knew that, I'd read many of them, they just weren't necessarily being followed.

144. There were serious incident forms as well, that you were meant to fill in when certain things happened. Some people filled them in and sometimes people didn't. If a senior didn't like the detail on a form, it wasn't unknown for them to just rip it up. I saw that happen. KEH [redacted] once ripped up a serious incident form I gave him which related to a physical assault on myself.

Hopes for the Inquiry

145. This has to be about transparency concerning what's going on in places as that's what has struck me most about this occasion. There was one man, one individual who wanted to keep what was happening, at the three units at St. Katharine's, secret.

146. LUZ [redacted] didn't update senior management properly, put fake documents in place for inspectorate's and minimised social work involvement at that unit. We need to be transparent and have a much wider input, not be secret and have self-run, self-managed groups and have some consistency across the board.

147. Howdenhall secure unit is only next door and when staff from there came to St. Katharine's they were as appalled as me because that regime wasn't happening in there. It was a secure unit in Edinburgh at the same time and was being run completely differently.

148. I believe a culture was created where anything could happen and I didn't see sexual abuse, but with that culture that was created anything could have happened, that would have been seen as acceptable and that is a terrifying thing.

149. 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.... KTS [redacted] .....

Dated..... 1-3-2019 .....