Wednesday, 12 February 2025

(10.00 am)

(Proceedings delayed)

(10.15 am)

LADY SMITH: Good morning, and welcome to the closing submissions in relation to Phase 8 of our case study hearings, this phase which started a rather long time ago.

I want at the beginning to thank everybody who has engaged in this lengthy and detailed phase of evidence. I know that Mr MacAulay is going to just summarise some more detail of what we have achieved. We couldn't have done it without the cooperation, engagement and dedication, if I can say, of so many who have helped us get to where we are today.

We are going to hear from a number of people today, tomorrow afternoon and Friday, at the end of which we will have heard from everybody who has had leave to appear in this phase and has contributed to the work that we have done.

First of all, we will start by hearing from Mr MacAulay, counsel to the Inquiry. Mr MacAulay.

Closing submissions by Mr MacAulay

MR MACAULAY: Yes, good morning, my Lady.

There has been a slight hiccup, which is why we are

15 minutes later than we had intended.

LADY SMITH: Yes.

MR MACAULAY: That might have an impact on the running order, but we will see as we go along.

LADY SMITH: Yes, I think we will just play that by ear, if you can bear with me I will let you know what's happening.

MR MACAULAY: As your Ladyship has just said, we are now entering the stage of concluding submissions of this case study that has formed Phase 8 of your Ladyship's Inquiry.

The focus of this case study has been on residential accommodation provided or used by the state between 1930 and 2014 to accommodate two classes of young people.

First of all, young offenders under the age of 18, including children and younger persons under 18 awaiting trial.

Secondly, children and young persons under 18 in need of care and protection.

These are the two broad categories and I will return to that shortly.

The accommodation that has been looked at was managed by a range of providers, including local authorities, religious bodies, voluntary bodies and also the Scottish Prison Service, as now known.

26 parties have leave to appear and, as your Ladyship has said, over the next three days will have the opportunity to make closing submissions.

A timeline has been prepared and parties have been told when it is expected that submissions will be made.

In the main, the providers of care, including, I think, INCAS, will make submissions today, tomorrow, and early into Friday.

Thereafter those with a more generic interest will make submissions, with submissions on behalf of the Scottish Government timetabled for the end of the submission process.

I then set out the background that the case study comprised of 12 chapters, beginning with the Scottish Prison Service (SPS) Chapter 1, and concluding with Chapter 12 last month, and that included Rossie, Wellington and Edinburgh Secure Services.

39 different establishments have been looked at. The case study began with opening statements on the 19 September 2023, followed by some introductory evidence over a period of 12 days, and I propose to return to that shortly.

Apart from establishments such as the Scottish Prison Service, the focus of the evidence has also been on approved schools, List D schools as they became after

the Social Work Act 1968, and when that system came to an end, residential schools.

Of the 39 establishments looked at, only five remain in existence for children under 18, which is quite a startling statistic.

LADY SMITH: Yes.

MR MACAULAY: These are the four secure units: the Good Shepherd, Kibble, St Mary's Kenmure and Rossie, the other being St Philip's Plains, and they are all run by charitable organisations.

I now want to touch upon the framework document, because that is --

LADY SMITH: Yes, the fact that these are all run by charitable organisations has been commented on by some witnesses, perhaps with a degree of anxiety, that that makes the availability of such provision perhaps more vulnerable --

MR MACAULAY: Yes.

LADY SMITH: -- although there are advantages in other ways, and it may be that the answer is it is just something to be aware of --

MR MACAULAY: Yes.

LADY SMITH: -- and the state needs to be aware of that, they could have to step in at any time.

MR MACAULAY: It may be something your Ladyship may have to

look at when she comes to make her findings.

LADY SMITH: Yes, indeed, thank you.

MR MACAULAY: Moving on then to look at what we refer to as the framework document. That has played an important role in this Inquiry and, to explain, in advance of the case study hearings, over a period from April 2023 to September 2023, with one exception, parties were issued with what has been described as the framework document.

The accepted provider was not granted leave to appear until later, and was sent the framework document in February 2024.

That document comprised of two parts. Part 1 referred to, for example, approved schools, List D schools, secure units and establishments within the jurisdiction of the Scottish Prison Service, and set out material then ingathered or identified by the Inquiry.

LADY SMITH: Yes.

MR MACAULAY: Part 2 listed a number of potential themes.

LADY SMITH: Just before you perhaps go to those themes, Mr MacAulay, I should perhaps interject for anyone listening who hasn't actually seen the framework document, this is a substantial piece of work and it was able to be put together because of the amount of written material that we have been able to recover, the assistance that we received from organisations in

answering our very specific questions in quite lengthy statutory orders to them requiring them to answer questions about their history and provision.

It meant that we started this long, long phase of work with a background of what looked like some reliable knowledge about quite a number of matters, and then, of course, we built on that as we have gone on through the oral evidence.

MR MACAULAY: I think, to put it another way, we had a running start.

LADY SMITH: We did.

MR MACAULAY: Which made a big difference to how the case study progressed.

LADY SMITH: We did, but this isn't a back-of-the-envelope job, far from it, it is quite a thick volume, as those of you who have studied the framework document will know.

MR MACAULAY: Yes.

Part 2 of the document listed a number of potential themes that the Inquiry was able to identify from the materials it had before it. Some of these themes I set out in the written submission, and I have a list, and I will make reference to some of these, beginning with the forms and prevalence of abuse and comparisons between different kinds of establishment, restraint,

corporal punishment and physical abuse, and clearly that was an important matter, because it was identified as an issue by many, many applicants. The use of segregation and isolation as a form of punishment, the organised sexual abuse, or exploitation, of young people.

An important theme also that was identified and, indeed, became a matter covered in the evidence, and that was the whole issue of staff recruitment, training and culture. That links into the theme of there being unsuitable staff looking after vulnerable children.

Reporting and complaints was a theme that was identified. The knowledge that providers had, and inspectors in particular, and I will look at that in a moment, was also a theme that was identified in the framework document. Management, understaffing and funding was also identified.

There is a list there of about 17 or so of themes that were identified in the framework document, and clearly the issue then became: would these themes emerge from the actual evidence?

Can I say, my Lady, there has been evidence relating to all the themes that were identified, but some issues stood out. The extraordinary prevalence of physical abuse and grossly excessive punishments under the guise

of corporal punishment, and we have had a lot of evidence on that.

The use of seclusion, or isolation, as a punishment, sometimes for lengthy periods, sometimes days.

LADY SMITH: Mm-hm.

MR MACAULAY: There has been evidence also on the propensity of some unsuitable staff, often those in charge, to abuse their power to impose severe physical punishment, and, indeed, sometimes to abuse sexually, and again another theme, more recently, the failure, for example, at St Katharine's and Kerelaw to learn from and apply the lessons of previous inquiries.

That is a failure, if I can say, my Lady, that ignored how the care environment could be improved for the children in care.

LADY SMITH: Yes.

MR MACAULAY: The framework document also contained an appendix setting out the relevant regulatory history as identified in the work of Professor Norrie, but to repeat, the primary purpose of the framework document was to ascertain in advance of the public hearings the extent to which factual matters set out in the framework document were to be challenged, and the basis for any challenges.

It is the case that few challenges have been made,

and where there have been challenges, the requests have been for amendment of the framework document. Can I say, that really misunderstands the purpose of the framework document, but it certainly is the case that when your Ladyship comes to make findings, your Ladyship will have regard to the challenges that have been made.

To the extent that factual material has not been challenged, or disputed, the framework document becomes a document that your Ladyship can draw upon when findings are being made. In that sense, it becomes a document that clearly has served to improve the efficiency of this case study.

My Lady, as listed above, a number of potential themes were identified in the framework document from an analysis of the material available to the Inquiry at that time, and in large measure, if the evidence is generally accepted, these themes have emerged from the evidence. Can I then just turn briefly to facts and figures.

Having started the case study on 19 September 2023, the evidential hearings were not concluded until last month, on 31 January 2025.

If one includes the days set aside for these closing submissions, 154 days will have been spent in hearings. The total number of applicants included in the case

study was 554, and 133 applicants have provided oral evidence.

LADY SMITH: 454? Not 554.

MR MACAULAY: I am sorry, 454.

LADY SMITH: Overall 454 applicants and then --

MR MACAULAY: 133 have given evidence and another 101 non-applicants also gave evidence.

LADY SMITH: It is also important to note that although only, 'only', 133 gave oral evidence, we covered the evidence of many other applicants by reading in --

MR PEOPLES: Indeed.

LADY SMITH: -- in some cases virtually all their statements, in other cases the parts that were relevant to the particular institutions in this case study.

MR MACAULAY: The period directly covered by that applicant evidence ranged from the 1950s to the 2000s, with the preponderance of evidence stemming from the 1960s, 1970s and 1980s. These statistics highlight how extensive this particular case study has been.

LADY SMITH: Just to add to that timeframe, of course, in the usual way, because the timeframe for this public Inquiry extends back to what is called 'within living memory', and we generally interpret that as back to 1930 and ends at the end of 2014, our investigations were always looking at the entirety of that period. But the

dates that you have identified, Mr MacAulay, are where we were finding most of the relevant evidence.

MR MACAULAY: Yes, indeed, and much of that is explained by the fact that the further back you go, the fewer applicants you will come across, for obvious reasons.

LADY SMITH: Yes.

MR MACAULAY: It is possible -- and there is one exception to this -- to break down the cohort of applicants by type as to when they enter the care system. Going back to what I said at the beginning, firstly applicants who were offenders and under 18, and applicants under 18 who were in need of care and protection.

It is quite striking that of the 454 total number of applicants, 313, approximately two-thirds, entered the care system in need of care and protection. That is quite a striking figure. That is not to say, of course, that having entered the care system, some applicants did go on to commit offences, but that statistic does chime with evidence from applicants of being placed in establishments with children who were offenders, and some applicants found that a very difficult position to be in.

LADY SMITH: Yes. Not just applicants, there were one or two other witnesses, other witnesses who commented on these children having been put there because the state

assessed them as being in need of care and protection full stop, were living in the establishments shoulder to shoulder with children who were put there because they were seen as having committed offences.

MR MACAULAY: And sometimes serious offences.

LADY SMITH: Serious offences.

MR MACAULAY: Can I say that that statistic of course reflects those formerly in care who came forward to the Inquiry --

LADY SMITH: Yes.

MR MACAULAY: -- and that's an important caveat.

LADY SMITH: Mm-hm.

MR MACAULAY: Can I then, my Lady, move on to look at some of the introductory evidence. The case study began with introductory evidence with input from a number of sources, beginning with Professor Kenneth Norrie on 20 September 2023, and culminating with evidence from Professor Andrew Coyle on 6 October 2023. I will look briefly at some of that evidence.

Beginning with Professor Norrie, he had prepared a report in connection with evidence he had previously given, and the intention at this point was to focus on legislation of particular relevance to this case study. He made the point that rules and regulations for various care settings differed on matters such as discipline and

punishment, so that vulnerable children in one care setting could be treated differently to vulnerable children in another care setting.

Furthermore, a child who had been placed in a particular care setting and moved to a different care setting could be faced with a different punishment regime, a scenario that was bound to cause confusion to the child.

As I go on to point out, the evidence in this case suggested that the majority of applicants were in more than one placement, and often in more than one falling within this case study. I set out some examples of applicants who were in eight placements, nine placements, I think, for the last example that I have made reference to, to show how haphazard the approach to the care of these children was over that period of time.

LADY SMITH: I think the last one you mention, actually, you counted ten.

MR MACAULAY: Ten.

I think your Ladyship, in an exchange with my learned friend, Mr Peoples, in Chapter 12, identified 14 placements.

LADY SMITH: Yes, from early on in that person's life --

MR MACAULAY: Yes.

LADY SMITH: -- from very early childhood. Constantly

moving from place to place.

MR MACAULAY: I think a similar picture emerges from the foster care case study.

LADY SMITH: Oh yes.

MR MACAULAY: Many applicants spoke about not having been provided, at the time, with information about, for example, how long a placement would be for, and if, and when, and where they would be moved.

Professor Norrie also drew attention to the importance of the roles played by persons such as headmasters under regulations, specifying that the discipline of an establishment was to be maintained by the personal influence of the person in charge, so that it was entirely up to that person how disciplinarian the environment was to be.

He was taken to a number of documents in Scottish Education Department files that had previously been looked at by Professor Levitt, including the document 'A History of Heads', dated 29 June 1967, that was written by one of the two inspectors responsible for approved schools at that time, with the conclusion that:

'The story certainly does not add up to good selection by managers, or, indeed, to good management.'

That was recognised at the time within the inspectorate. That was against a history of

resignations of people in charge of named approved schools for a variety of offences, including 'sadistic cruelty', that was for Dr Guthrie's School, 'cruelty' and 'abuse' in Kenmure St Mary's. He also looked at internal office correspondence between officials, including by one of the inspectors, Inspector Murphy, that disclosed that the Inspectorate was well aware of the brutal beatings administered to boys in approved schools, with the conclusion that what was recognised as happening:

'... was a reminder of the terrifying power of a headmaster in these schools.'

That's the quote from the document, not from Professor Norrie.

As I said, that material had previously been looked at by Professor Levitt. From Professor Norrie's perspective, what was being described in that documentation was a general picture of systemic failure rather than, as he said, 'The one bad apple situation'.

Professor Norrie also compared the limited powers available historically to the Inspectorate, limited to making recommendations, and the powers available to the Care Commission after 2002 and the enactment of the Regulation of Care (Scotland) Act 2001.

The delay in such a significant shift in the

inspector's powers was described by Professor Norrie as 'shocking and surprising'.

In relation to qualification and training, he said that the lack of training and appropriate qualifications had been 'an inexcusable failure' and that even in what he described as the modern welfare state, how:

'The state was prepared to tolerate for so long the care of vulnerable children by unqualified, untrained, and inexperienced staff.'

Professor Norrie was followed in evidence by Maree Allison. She was the Director of Regulation for the Scottish Social Services Council, otherwise referred to as SSSC.

She gave evidence that when the SSSC was set up, it was under the 2001 Act, only 20 per cent of the workforce had relevant qualifications. That's as recent as 2001.

LADY SMITH: Yes, not long ago.

MR MACAULAY: Yes, and because of the increasingly complex needs of children and young people and professional tasks that required high-level abilities, the SSSC had developed in 2016 a benchmark Scottish Credit and Qualifications Framework (SCQF) for all care workers to be at level 9. That level could include a number of different qualifications, for example an ordinary

degree. This benchmark arose out of the Scottish Government's acceptance of recommendations as far back as 2012.

LADY SMITH: Yes.

MR MACAULAY: This has not yet been implemented, and at the date of giving her evidence, Ms Allison said that they had asked the Scottish Government what their intentions were and they were awaiting a decision regarding implementation.

It may be that Ms O'Neill, when she comes to make her submissions, can provide an update on that.

LADY SMITH: It would be very helpful if she did so.

MR MACAULAY: I then turn to some of the evidence provided on behalf of the Care Inspectorate. That was from Andrew Sloan, who was a team manager, and Helen Happer, a Chief Inspector, and they gave that evidence over a period of two days. The Care Inspectorate do have leave to appear and so are in a position to develop their position in their closing submissions.

What I would say at this point is that there was a recognition by them that when the Care Commission was set up there was a clear need for change, because prior to implementation of the 2001 Act, the inspector regime was 'outdated', by which was meant there was a clear desire to move inspection away from the organisations

who were commissioning the service, for example local authorities, to a much more independent body, and provide for consistent national standards.

One question your Ladyship may wish to address, as indeed suggested by Professor Norrie: was this change so belated that children in care were unnecessarily exposed to abuse because of a defective inspection system?

What is clear from this evidence is that the prior inspection process, as Professor Norrie claimed, risked inconsistent approaches by different local authorities. He described the approach as 'fragmented'.

In their evidence, Mr Sloan and Ms Happer went on to describe how the present system has developed with the involvement of what was called a quality framework approach. They went on to describe the challenges that they faced as an Inspectorate, and that in particular they are very dependent on what they see during an inspection and what they are told, and especially what information they could acquire from young people.

That is a challenge because, from the perspective of the young people, the inspectors are strangers.

LADY SMITH: Mm-hm.

MR MACAULAY: They are also dependent on the particular service's honesty in informing them of potential issues.

Ms McManus, who I go on to look at, gave evidence on

behalf of Education Scotland. Education Scotland is the successor to Her Majesty's Inspectorate of Education, and other organisations involved in education, and was established really quite recently, in July 2011. It was established as an executive agency of the Scottish Government.

She had also given evidence in the boarding school case. She was the Strategic Director for Security for Education Scotland, and in that role had a role to play in connection with inspection.

Education Scotland provided a number of reports, and I have listed the reports. I am moving on to the following page. One of the documents they provided was referred to as annexe A, and that was a document that extended to 612 pages of establishment reviews relevant to this case study that was based on their examination of all available records.

It was clearly a significant piece of work, and one of the reports they produced provides a summary of what they found.

In short, the records referred to in annexe A show that over many years, children accommodated in establishments under investigation in this case study were subjected to practices, conditions and regimes that were abusive. The conclusion arrived at based on that

material was the remit of the Inspectorate historically was insufficient to protect children in care. That was their conclusion.

LADY SMITH: Of course that takes us back to how late in the day it was that the Care Commission --

MR MACAULAY: Yes.

LADY SMITH: -- was created.

MR MACAULAY: Indeed.

LADY SMITH: Before then the only outside eye you could look to, really, was Education Scotland, or something commissioned by the particular local authority, for example, on an ad-hoc basis.

MR MACAULAY: The message here, my Lady, is that they had the material there to tell them --

LADY SMITH: Yes.

MR MACAULAY: -- that children historically were being abused and that the Inspectorate historically was insufficient in its powers to protect children in care. Indeed, I think she accepted, under questioning, that she was unable to point to evidence in those records as to how the known abuse was responded to.

The other point, I think, that she made was that the catalogue of references to abuse contained in the records was acknowledged as likely not to represent the true nature and extent and scale of the abuse of

children in the care of the state. I think we have seen that in other case studies. We are just getting a glimpse into the extent of the abuse that was being perpetrated.

LADY SMITH: You have an organisation that didn't have sufficient powers. It had information that had red flags on it. The answer could be well, they didn't have the statutory powers to do anything specific about it, but at the very least they could have raised that issue: 'We are seeing problems, we are seeing matters that are extremely concerning, what is somebody -- the state, for example -- going to do about this, because it doesn't seem that we have the power to intervene and take action?'

MR MACAULAY: Education Scotland was an agency of the state.

LADY SMITH: Indeed.

MR MACAULAY: In summary, Education Scotland accepts that it, and in particular its predecessors, were aware of the abuse and harmful practices in a number of relevant establishments.

Against that whole background, she repeated in person the acknowledgement that children were abused and the apology made by Education Scotland in its response to the Inquiry.

What also emerged from her evidence is that the

Scottish Ministers took the decision in June 2021 to relieve Education Scotland of its inspection function in recognition of the need for a more independent inspectorate. When she gave evidence, there was no draft bill, but the Programme for Government 2023/2024 did include a commitment to introduce an education bill that would include a provision for the creation of an independent inspectorate.

By looking at the SG website, it is the case there is now a draft bill making its way through the parliamentary system. Again, Ms O'Neill might be able to give us an update on that.

LADY SMITH: That's a shift from an agency to a completely independent inspectorate?

MR MACAULAY: No doubt to mirror the shift to the Care Commission and the Care Inspectorate.

LADY SMITH: And, as we have also seen in this phase, the Inspectorate of Prisons?

MR MACAULAY: Yes, indeed.

LADY SMITH: Yes.

MR MACAULAY: But I think the Inspectorate of Prisons still remains an executive agency of the Scottish Government, and I will perhaps just touch upon that.

LADY SMITH: It may do. But the inspector herself is an independent statutory appointment.

MR MACAULAY: It is.
LADY SMITH: It is a public appointment. She, Wendy Sinclair, even made a point of explaining that and certainly regarded herself as entirely independent.
MR MACAULAY: Yes. I am reminded, I think she is a statutory appointment --
LADY SMITH: Yes.
MR MACAULAY: -- albeit, I think, paid by the Scottish Government --
LADY SMITH: Yes.
MR MACAULAY: -- and the staff are also paid by the Scottish Government.
LADY SMITH: Sorry, I digress.
MR MACAULAY: Moving on in fact to the Scottish Prison Service, as it is now known. There was also evidence in this introductory phase from witnesses who had been involved with the prison service. Although much of this evidence is important from a historical perspective, because children under 18 were accommodated in SPS establishments. As I mention shortly, that position has changed. I don't propose to look at this evidence in any detail at this stage, but can I say in broad terms, the evidence here from the witnesses who gave evidence was that they were in agreement that under 18s should not have been in the prison service, and that the prison

estate generally was not in a good state, although much had been done to improve it.

One of these witnesses was Sue Brookes, who gave evidence about the evolution of SPS since she joined as an assistant governor in 1987. While governor at Polmont between 2012 and 2017, and at that time she said Polmont accommodated 16- and 17-year olds, but in certain circumstances also 15-year olds, she was part of an aim to create a learning environment for young people as well as seeking to reduce the incidence of bullying and self-harming. In that connection, she introduced a range of initiatives, and I set some of that out there.

The general aim going forward was to make SPS an organisation that takes a trauma-informed approach to the care and management of all persons in SPS establishments. As I mentioned a few moments ago, it was her view that in any civilised society, no child should have been detained in a penal establishment.

Professor Andrew Coyle gave evidence. He had a lengthy connection as a governor and in other roles with the Scottish Prison Service between 1973 and 1991, including being, I think, an assistant governor at Polmont Borstal between 1976 to 1978.

One of the comments he made -- and this has been

reflected in the evidence -- is that during his period with the Scottish Prison Service, he encountered many individuals who made what he described as 'the typical journey' through the care and justice system, including borstal and young offenders' institution and from there to adult prisons, including in some cases to His Majesty's Prison in Peterhead, which he described as 'the bleak fortress'.

Indeed, when he became governor of Peterhead in the 1980s, he encountered prisoners he had met in Polmont years earlier, so much so that they were on first name terms from the outset. He spoke of a strong push on the part of former chief inspectors of prisons, such as Dr Andrew McLellan, to have under 18s taken out of SPS custody.

He gave evidence more generally about attempting to reduce the Scottish prison population, and, from around 1990 onwards, to bring about a change of culture involving better training for prison staff and caring in a more humane and human rights compliant way for prisoners. But he went on to say there were and still are no qualifications required of prison officers, in contrast to other organisations.

He went on to say on page 14 that the key to a good prison service -- he described this as a clich --

depends on the relationship between staff and detainees and the ethos and atmosphere of the environment, and that may look self-evident to most people. There is also a need for an independent and transparent complaints system, and he appeared to favour an independent complaints body with power to entertain and adjudicate on complaints by prisoners.

LADY SMITH: Professor Coyle also provided us with at least one interesting example of how modelling the right way to treat prisoners works if you are the leader, modelling it as the leader --

MR MACAULAY: Yes.

LADY SMITH: -- and modelling it in a way that other staff see, and making it clear to other staff how they should treat those who are detained.

MR MACAULAY: He made it perfectly clear that the governor, and the examples he gave, just like a headmaster at a school.

LADY SMITH: Yes.

MR MACAULAY: Has to play such a critical role.

LADY SMITH: Yes, and one of the key aspects of it is showing respect for the person who is in the residential institution, particularly if they have been detained there against their will.

MR MACAULAY: He was critical in some respects of the

current mechanisms for inspection and monitoring.
LADY SMITH: Yes.
MR MACAULAY: And he thought, unlike Wendy Sinclair-Gieben -- that I will look at in a moment -- that the Prison Inspectorate in Scotland should have some powers of enforcement, because Wendy Sinclair-Gieben disagrees with that. But he did balk, I think, at the idea of actually giving the Inspectorate the power to shut a prison down. I suppose if one looks to a prison like Barlinnie, that probably explains why he wouldn't go quite that far.
LADY SMITH: No.
MR MACAULAY: He went on to say that while in many ways the Scottish Prison Service had changed 'beyond recognition' since he started there in 1973, he also said it is 'in other ways, it's old wine in new bottles'. He in particular identified the pressure of numbers on the system, which militated against real progress, as well as the largely Victorian prison estate and that the issue of staff training also remained a major issue.
LADY SMITH: We know, from what we read in the press, amongst other places, that that pressure of numbers has not gone away.
MR MACAULAY: No.
LADY SMITH: It hasn't diminished since the autumn of 2023

at all.

MR MACAULAY: Yes. I think we know also that, if we take Barlinnie as an example, that it appears to be in a fairly bad way --

LADY SMITH: Yes.

MR MACAULAY: -- with the expectation at some point of there being a new prison.

LADY SMITH: Yes.

MR MACAULAY: Another witness who gave evidence in connection with this area was Alec Spencer, on Day 379. He had joined the Scottish Prison Service in 1972, initially as an assistant governor, and he worked in various establishments, including Glenochil, and I think also in Polmont Borstal, in various positions.

He described Glenochil as being a place -- we heard this in other evidence -- where the philosophy was that of the short, sharp shock. At one point he said this would really be a licence to impose harsh treatment, and so far as Polmont Borstal was concerned, he said that the edge between discipline and brutality became blurred. That's how he put it.

He did provide the Inquiry with a transcript of an audio recording from a former inmate at Glenochil who went there in 1968, which was received in March 1985 by the Dr Chiswick inquiry into suicides at Glenochil.

That transcript, which I think it may have been read to your Ladyship during this chapter --

LADY SMITH: Yes.

MR MACAULAY: -- describes various abusive incidents involving that former inmate and other boys. He also described how he himself dealt with an allegation of inappropriate behaviour by a chief officer in about 1987, and the allegation being that this officer would sit young offenders on his lap in his office and, in so doing, put a covering over the window of the office door to conceal his activity. He spoke to the officer, who didn't deny the allegation. He suggested to the officer that he should end his employment, failing which the matter would be reported to the police. The officer resigned and, having done so, Mr Spencer took no further action.

One of the important general points he made during his evidence was that in a closed environment there is always an imbalance of power between staff and residents, and in such an environment abuses through, for example, the abuse of power, can occur. As he put it, prisons are a very coercive environment. He too favoured the abolition of imprisonment for under 18s.

We have already mentioned Wendy Sinclair-Gieben who gave evidence that she was the Chief Inspector of

Prisons, a position she had held since 2018, she resigned in 2024. She did provide evidence about the history of His Majesty's Inspectorate for Prisons in Scotland, and I think they also have leave to appear --

LADY SMITH: They do.

MR MACAULAY: -- so no doubt will provide your Ladyship will submissions later on.

She explained how the current monitoring system, that she referred to as the independent monitoring system, using volunteers, would report to the chief inspector and they would inspect, to use that word, on a weekly basis, whereas the Inspectorate itself would inspect once every four years. She also gave evidence about the inspection process, including the use of standards, grades and quality indicators as part of that process. She made it clear that the Inspectorate's role was to contribute to preventing abuse, rather than detecting abuse, and indeed that was the same message from the Care Inspectorate. As your Ladyship pointed out, whilst the chief inspector is a statutory appointment, her staff are employed by Scottish Government.

She described the current complaints process. Complaints are not investigated by the independent monitors or the Inspectorate. The two available routes

were through a prison service process or through the NHS, but in given cases, reports would be made to the police.

She did say that her fundamental belief is that those under the age of 18, if they require to be detained in secure conditions, need 'a therapeutic environment' that looks at their identified needs and starts to work with them. Keeping children in prison was contrary to international rights, conventions and standards.

She also described how constant issues for the Prisons Inspectorate over the years were how much time a prisoner, or young person, would have out of cell --

LADY SMITH: Yes.

MR MACAULAY: -- against evidence that they could be locked in a cell for 23 hours a day, and meaningful activity for young people, especially young people on remand.

Another issue was that those detained very rarely had a proper understanding of their rights, and she also mentioned the segregation of young people being another issue.

She went on to say that there had never been any legislative requirement for prison staff to have particular qualifications, and there was no workforce regulator similar to that of the SSSC that could

prescribe minimum qualifications and, through a system of compulsory registration, effectively terminate employment of a prison officer who abused children or posed them a risk of harm.

She talks about the enforcement issue, to confirm that the chief inspector has no powers of enforcement, there was no system of registration for prisons, as there is for the Care Inspectorate. She did not favour having powers of enforcement, such as the power to issue directives, unlike Professor Coyle, because she thought that that would impact upon her good relationship with the prisons, and I think may have regretted saying this, but she referred to the prisons as 'a critical friend'.

LADY SMITH: Yes, yes. That she was the critical friend.

MR MACAULAY: Yes, she was the critical friend.

LADY SMITH: Yes.

MR MACAULAY: I think she was pressed on that.

She said that prisoners at every inspection would tell inspectors they have no confidence in the complaints system, that prisoners would prefer an independent complaints body rather than, as at present, the SPS investigating complaints other than those which meet the threshold of police involvement.

My Lady, moving on to the Scottish Prison Service, the first chapter of the case study focused on the

Scottish Prison Service and in particular applicants who had been in a prison environment. In that context, therefore, it is worth mentioning the important change that has emerged, since that evidence was given, as to what young people will come within the prison service and the Children (Care and Justice) (Scotland) Act 2004 came into force on 16 July 2024.

That Act made a number of changes in relation to how children are dealt with within the justice system. For example, the meaning of 'a child' in the Criminal Procedure (Scotland) Act 1995, and that's section 307, is amended to mean a child under 18, rather than under 16.

I think, and again Ms O'Neill maybe will be able to clarify this, that provision came into force on the 29 August of last year. That change of meaning extended the jurisdiction of the children's hearings to include under 18s and not just under 16s.

LADY SMITH: Yes.

MR MACAULAY: In essence, that removed young people out of the prison system.

That has, of course, already been happening in practice, because, as at September 2023, there were only five or six young people under 18 in young offenders' institutions.

I then go on to a section that is focusing on applicants. I begin by saying I do not intend to rehearse the evidence of the many applicants who gave evidence in 12 chapters in the course of this case study. I have already mentioned the prevalence of physical and sexual abuse, and abuse practices.

The message from many of them, and can I say this is really acknowledged across the board by the providers, and corroborated in contemporaneous records, is that they were subject to abusive regimes whilst in care.

As your Ladyship will recollect, there have been a significant number of convictions --

LADY SMITH: Yes.

MR MACAULAY: -- relating to the physical and sexual abuse of children in care. The earliest conviction of which the Inquiry is aware is actually way back in 1936, which involved a janitor who was convicted of a number of assaults.

LADY SMITH: Is that the conviction in relation to which we have documents, a transcript of the proceedings, or some of the proceedings?

Yes, I think Mr Sheldon's nodding his head.

MR MACAULAY: Nodding of heads, my Lady.

LADY SMITH: It is really quite detailed, and gives us particular insight into how things were handled at that

time.

MR MACAULAY: Yes, it gives an insight into what disposals were done.

LADY SMITH: Yes.

MR MACAULAY: What I would like to do, my Lady, is focus in connection with applicants on these particular themes: the impact upon their lives that they associated with the abuse they suffered and the legacy that those who ought to have cared for them inflicted upon them. Secondly, their motivations for giving evidence. Thirdly, that as children, in the main, they did not report abuse, and when they did, they were not heard.

I go on to look at impact and, across all establishments, applicants spoke of that impact, often lifelong, that their experiences in these settings left with them. I set out some common themes. Having a lack of trust in people was a significant impact for this cohort of applicants.

LADY SMITH: Yes.

MR MACAULAY: Because it affected the way in which they dealt with people all their lives, particularly people in authoritative positions.

The second impact: a negative impact on education and lifelong learning. This particular theme was not in fact foreshadowed in the framework document, but many

applicants did describe the failure to provide any adequate education and what impact that had on their lives.

The irony here is that in many cases children were sent to approved or List D schools because they were not attending mainstream schools.

LADY SMITH: Yes.

MR MACAULAY: Applicants also spoke about an inability to form and maintain relationships, the fear of a feeling of shame about sharing their experiences with, for example, partners and family and the belief that being in these settings in the first place introduced them to a life of crime, in that that's where they learned how to become involved in such a life.

We have also had evidence about the impact on the mental health of some applicants in many cases leading to addiction to alcohol and/or drugs.

I go on to say, my Lady, that in terms of their lives now, some applicants provided evidence that they were in a more positive place than they had been in relation to the impact. In some cases, the evidence was that this happened through a particular relationship with a partner or a successful family life. Others spoke of a change in their lives coming about by their realising they were able to make a positive contribution

to the lives of others, or society more generally.

In relation to motivations, a number of applicants wished to make clear that they were providing their evidence not only to share their recollections of their own treatment in these settings, but also the experience of others, siblings or friends, who are no longer able to share their own experiences. Many also wanted their voices to be heard so that children in the future would not be exposed to abuse.

Insofar as reporting is concerned, the evidence of many, indeed if not most, of the applicants throughout this case study was they did not report what was happening to them in these settings at the time. Some said they had no one to tell. Some said they had been scared to do so. Some feared that reporting would have made their situation worse, and some said that as children they did not know what was happening to them constituted abuse.

The evidence of many was that they feared they would not be believed. Some applicants described being warned not to report and being told there could be real consequences for themselves or their families if they did so. Many applicants did not recall anyone from external agencies visiting these settings. Some said there may have been officials visiting, but that the

purpose was not to speak to the children. Some applicants spoke of not seeing, or having contact with, their own social workers for years while in a particular setting.

Some applicants did speak about reporting abuse, including to family members, staff, social workers, police, and, indeed, to the Children's Panel. The evidence suggested that in the main such reports were not investigated or passed on.

Throughout this phase, this case study, there was evidence from applicants and former staff that there was a lack of mechanism almost across the board in the settings considered for any such reporting by children, including for follow up and investigation and, importantly, for any support being provided for a child who made a report. As time went on, such mechanisms did emerge, and establishments such as Kibble and St Philip's were transformed, really, in the more recent past.

So my Lady, to conclude, this has been a major case study. If the evidence is accepted, and, to repeat, it has not been challenged by providers, and, indeed, providers have acknowledged that there was widespread abuse of children in care, then your Ladyship may have little difficulty in concluding that there were abusive

regimes and systemic failures.

When allied with the evidence of Professor Levitt from his analysis of the available records, some of which were put to Professor Norrie, and other records available, as, for example, identified by Education Scotland, there is a basis for your Ladyship to conclude that the state knew that abusive regimes existed and that the state failed to protect children in its care.

LADY SMITH: Indeed.

MR MACAULAY: My Lady, those are my submissions.

LADY SMITH: Thank you very much, Mr MacAulay.

I now would like to invite Ms McCall, who is here on behalf of the INCAS, to present their closing submissions.

Ms McCall, when you are ready.

Closing submissions by Ms McCall on behalf of INCAS

MS MCCALL: My Lady, can I first of all apologise for not being here in the scheduled slot. I appreciate the Inquiry puts time and thought into the order of submissions. There was a simple diary error at our end, so my apologies for the inconvenience.

LADY SMITH: My thanks to you for getting here as quickly as you can, I am grateful to you.

MS MCCALL: My Lady, turning, then, to the closing submissions for INCAS.

At the close of this case study, INCAS reiterates the importance of remembering that all children accommodated in the institutions with which this case study is concerned were vulnerable. They were removed from their families and communities and placed into the care of the state, sometimes very far from home.

Whether they were sent to an establishment because they were alleged to have committed offences, because they were failing to attend school, or because they were in need of care and protection, they all deserve to be treated with dignity and respect. But the evidence in this case study has shown time and again that staff lost sight of the fact that these were children with individual needs who deserved support and protection.

In their opening submission for this case study, INCAS set out what they believed the evidence would show, and sadly their belief has again proved to be well founded. Children were subjected to abuse of every kind; physical, sexual, emotional. They were abused by staff, they were abused by their peers and often with impunity. They were treated not as children but, as one witness put it, as prisoners with no rights.

Rather than invite particular findings in relation to individual institutions or in respect of specific examples of abuse, which findings we anticipate your

Ladyship will make in any event, this closing submission endeavours to draw together some common themes that have emerged from the evidence, and set out INCAS's hopes for the future. Where examples are mentioned of particular institutions or individuals, they are chosen simply to illustrate the issues that came up time and again in the evidence.

First of all, dealing with placement of children. The evidence has shown a failure to place children appropriate to their needs and the reasons for them requiring care. Children who were in need of care and protection were accommodated alongside children who were alleged to or had committed criminal offences. Children were admitted for a litany of reasons: parental neglect, failure to attend school, family breakdown, as well as for criminal offending, ranging from the minor to serious offences, including sexual offences. The state failed to view children as individuals with their own, often complex, needs. As 'Cathy' put it in relation to Langlands Park:

'Someone like me should never have been in the school in the first place. I wasn't in gangs. I wasn't a criminal. All I was doing was not going to school because I was scared.'

Children may have been accommodated initially

because of, for example, a failure to attend school or because of changes in their families, but they progressed through a number of increasingly secure residential homes until they ended up caught up in a life of crime. The Inquiry's heard numerous examples from witnesses, one such was 'Ray', he had initially been placed at Smyllum after his mother died and his father couldn't cope. He was then at Calder House, St Ninian's, St Philip's, St Joseph's and Rossie. He suffered and witnessed abuse. From there, he found himself in Longriggend, and on to Barlinnie, and Glenochil. He described being in and out of prison for most of his life. As he put it:

'My time in care has shaped and defined my life. The abuse has obviously really affected my life. I had never really thought about it until recently. My life's been hell. Being in and out of borstal and prison was my life. Being locked up was all I'd ever known until I met my wife and had three kids.'

The progression of 'Ray' and those like him from care to prison was entirely predictable and significant steps ought to have been taken to prevent it.

Dealing with the nature of the regime. In INCAS' submission, the system of List D and residential schools was not fit for purpose. Many who were accommodated

there had been traumatised already by their life experiences. The regime in these institutions not only failed to take account of the children's experience of trauma, but in many instances compounded it. Witnesses described in essence a military regime at many institutions, rather than one of care. There was no sense that staff saw children as individuals to be guided and nurtured. Rather, the ethos appears to have been one of brutalising children into conforming or submitting to authority.

In terms of education, another repeated theme was the lack of education provided to children. As was acknowledged, for example, by CrossReach in respect of Ballikinrain, Geilsland and Langlands Park, the level of education was poor.

At Larchgrove, the Bennett and Righton report found that there was not one qualified teacher in the classrooms, but even after that review, the Inquiry heard evidence of children placed at Larchgrove as a result of non-attendance at school, only to receive no education there either.

At Cardross Park it has been recognised that the education provision was limited at best. There was no intention or effort to motivate children to learn. In lessons, artistic activities were provided, which are,

of course, important but not as a replacement for academic endeavour.

At Thornly Park it appeared boys were made to work instead of being educated, although there was some evidence that they were given a couple of hours of basic reading and writing.

It was a similar story across a range of establishments, and no doubt there were a variety of reasons why education was not prioritised. There was evidence of staff shortages, lack of staff training to deal with learning difficulties, poor handovers from school or social work to the establishment and children already disincentivised from learning.

Whatever the reasons, there was no justification for this fundamental failure in the state's duty to provide an education to its children. Vulnerable children were again failed by the system. It's a particular irony that children were sent to these establishments because they were missing out on education through truancy and other reasons, but then received no meaningful education. The attitude of the authorities appears to have been that these children were not expected to achieve anything.

Witnesses spoke movingly about the lasting impact lack of education has had on their lives. Some

considered that the lack of education resulted in them becoming criminals and spending much of their life incarcerated rather than pursuing their ambitions.

Turning to training, there is a body of evidence which would allow the Inquiry to conclude that many staff in secure care establishments were not properly trained. In some instances, the lack of training was known at the time.

For example, in 1964 there was a disturbance at Langlands Park. The inspection report which followed identified the cause as the traumatic background of the children and a failure to address that with psychological support. The education department noted that staff had no relevant training and had no time to address these issues in the youngsters.

In Larchgrove, a lack of training appears to have been the norm. Bennett and Righton noted:

'The overwhelming majority of supervisors are untrained in residential work at any level. It is alarming that the induction procedure for newly appointed supervisors is so haphazard and sketchy.'

At Kerelaw, when 'Robert' was employed in 1990, his evidence was that he did not need a childcare qualification, he learned on the job by shadowing others. The Inquiry heard similar evidence from

'Peter'. The situation appears to have changed and improved over time with the introduction of assessment and verification of qualifications.

Turning then to the use of restraint, the Inquiry has heard a lot of evidence about this. While it is recognised that there may be occasions on which safe holding is necessary, a general theme emerged from the evidence that restraint was used inappropriately and disproportionately to forcibly subdue children. At times restraint was a smokescreen for planned assaults or retribution. As the Frizzell report found in relation to Kerelaw, but this also applies elsewhere, restraint was used as a first rather than a last resort.

The Scottish Prison Service have acknowledged that at Longriggend, Glenochil, Barlinnie and Polmont there was disproportionate use of control and restraint. As well as the inappropriate use of restraint, in many places there was a lack of training in restraint for staff. For example, Graham Haddow, a former teacher at Larchgrove, 1981 to 1982, spoke of the lack of training for all staff in relation to holds and restraints.

This pattern of inadequate training and inappropriate use of restraint was repeated across many of the institutions the Inquiry has considered.

I turn then to seclusion cells and other

punishments. There was widespread evidence of the inappropriate use of seclusion or isolation cells. By way of a typical example, the Inquiry has records indicating that at Calder House Assessment Centre, a detention room or cell was used as punishment. Numerous witnesses have described their experience of it. 'Jock' was locked in the cell for three days upon his arrival. 'CC' was held for a week in solitary confinement as a punishment for throwing a bucket of water over a staff member. When she deliberately flooded the cell, she was physically beaten.

It was maintained by a former matron there that the room was only used for overnight admissions, or for the safety of the child or others. She did not accept that its use would be abusive and noted that children were visited regularly while they were in there and given something to read. That may be considered illustrative of the failure at an institutional level to recognise what were abusive practices.

Aside from seclusion, the Inquiry has heard evidence of a variety of punishments inflicted on children: standing out, being made to stand still and straight for extended periods of time, pindown, having all one's personal belongings removed, extended outdoor runs, scrubbing floors with toothbrushes, stopping visits from

family and so on.

LADY SMITH: And stopping visits to family, as well.

MS MCCALL: Correct, my Lady.

LADY SMITH: Yes.

MS MCCALL: These appear to have been commonplace across a number of institutions. The Inquiry could conclude that their employment was designed to isolate, humiliate and degrade children. They were on any view an abuse of power by those in authority, none of these methods of punishment were appropriate.

Turning then to peer-on-peer bullying and abuse. It is clear from many sources that peer-on-peer bullying was a significant and persistent problem, affecting many of the institutions examined. The attitude in some places was to leave children, in this instance boys, to resolve disputes themselves. For example, the Inquiry heard that one method of staff intervention was to arrange boxing matches between the boys. At Kerelaw, this took the form of what was called horseplay, which downplayed the risks to the boys compelled to take part. The Frizzell report noted that horseplay still went on even after guidance against it was in place.

At Larchgrove there was evidence to suggest that organised fighting between boys was a form of entertainment for staff, with cigarettes and alcohol

being provided as incentives to participate. Boys who refused to take part may have been physically abused. There was evidence from 'Iain' that the winners were subjected to sexual abuse by staff.

Looking then at complaints and inspections. As has been seen in previous case studies, the evidence here has demonstrated once again that children either had no means to complain or if they did complain, they were not listened to or not believed. The evidence relating to Scottish Prison Service establishments demonstrated that their complaints process was not fit for purpose.

In terms of the inspection regime, the Inquiry heard numerous examples of problems being identified, but no clear action being documented. Where warnings were issued by inspectors, there appears to have been a failure to follow up to ensure that changes were implemented.

One such example was Geilsland School. Inspectors had concerns about the irregular punishment of boys, including hitting and handcuffing them. The issue was raised on a number of occasions with the headmaster and the Church of Scotland board of managers. The board of managers in fact instructed that corporal punishment should cease at the end of 1968, but it continued as a practice until 1983.

It has been acknowledged on behalf of Dr Guthrie's School that in certain instances abuse and cruelty was known by others to have taken place, but little or nothing was done.

The Inquiry has heard evidence that permits the conclusion that there was a pattern of failure to act on children's complaints, failure to act on inspector's criticisms and failure to follow through to ensure that changes were made.

There was, it might be said, a lack of curiosity or concern for what children were experiencing and a failure to join the dots to identify patterns of abuse. It was notable that what triggered the wide-ranging investigation into Kerelaw in 2004 were complaints by staff about bullying and harassment by a unit manager. It was not prompted by the complaints that had been made by children.

Children's Rights Officers visiting Kerelaw were said to have been prevented from speaking directly to the children. While there was a complaints procedure in place, it has been acknowledged that compliance was patchy and at times was deliberately frustrated. In the end, the inadequacy and inefficacy of any complaints system that might have existed gave rise to a widespread failure on the part of many of those involved in the

system to take responsibility for stopping abuse.

Moving on to some positive developments. INCAS welcomes the acknowledgement and apology issued by a number of providers to date in this case study. It is hoped that the apologies are meaningful and translate into support for survivors and into making and sustaining change.

INCAS is encouraged by the evidence heard about changes to practice by those who are today responsible for caring for children in these settings, including the introduction in some of trauma-informed practice. Staff working in residential childcare are now registered with the SSSC, providing regulation and oversight which helps ensure consistent standards of professionalism.

The introduction of the PVG scheme is also important in protecting children from abusers.

The development and introduction of various means by which children can speak to an independent person, whether that's through an app, such as in Aberdeen City, or via independent advocacy services, such as in Inverclyde, is a clear improvement on the experience of past years when children felt they had nowhere to turn if something was troubling them.

It is important that monitoring, inspection and learning continues, not just to ensure that bad

practices do not re-emerge, but also because learning about best practice is constantly developing. That's illustrated by the general welcome that was extended to the introduction of TCI in the 1990s. 30 years on, as your Ladyship recognised, a more sophisticated understanding is needed.

INCAS also hopes that the recent legislative developments incorporating the UN Convention on the Rights of the Child, and prohibiting the detention of under 18s in young offenders' institutions, will prove to be strong tools in securing better care for troubled children in the future.

In conclusion, as Janie McManus stated, it is unacceptable that any child was abused or subjected to abusive practice, conditions and regimes. Children attending educational establishments should have done so with the expectation that they would be safe and free from harm. For children who were abused, this was not the case.

Referring to reporting about a disturbance at Brimmond, Graeme Simpson summed up an attitude that was far from unique. It does feel as if this was a time when there was little control over the environment within there, and when children don't feel safe and held, they react in ways which are unpredictable, they

react in dysregulated ways. In some respects, the children were responding to the conditions in which they were experiencing life, and yet we turn round and we blame the children for their behaviours.

INCAS very much hopes that Scotland can finally move beyond the situations that were being described.

LADY SMITH: And of course, as witnesses have now explained, children speak through their behaviour.

MS MCCALL: They do, very much, my Lady.

LADY SMITH: And for too many decades that was not being recognised.

MS MCCALL: Very much so.

LADY SMITH: Thank you very much, Ms McCall.

It is now just after 11.30 am, so I will stop here for the morning break.

After the morning break we will move on to, I hope, hearing from Mr Thomson for the De La Salles and the Salesians of Don Bosco.

(11.35 am)

(A short break)

(11.50 am)

LADY SMITH: As I indicated before the break, I would now like to turn to Mr Thomson, who represents the De La Salle Brothers and the Salesians of Don Bosco.

Mr Thomson, when you are ready.

Closing submissions by Mr Thomson on behalf of the De La Salle Order

MR THOMSON: Yes, my Lady, thank you.

In the opening statement and closing submission, the De La Salle Brothers gave an unreserved and full apology to all those who were harmed.

They do so again today.

LADY SMITH: Thank you.

MR THOMSON: In their opening statement, the De La Salle Brothers committed to assisting the Inquiry with its investigation into the nature and extent of abuse. They also committed to learn from the past, and participate in any process which improves the protection and care of children. They renew these commitments.

Although their association with Scotland finished more than three decades ago, their desire to honour those commitments shall remain undimmed. Improving the protection of children will always be a core ongoing objective.

In their opening statement, closing submission and by their entire approach to the Inquiry, the De La Salle Brothers have acted in furtherance of the Inquiry's terms of reference and acknowledged failures on their part.

They also accepted the need for them to play a part

in creating a national public record of the historic abuse of children in care in Scotland. Attention must be paid.

Since the evidence session, the safeguarding lead of the De La Salle Brothers has further assisted the Inquiry by providing an addenda to the part D response.

LADY SMITH: Yes, I am grateful for that, Mr Thomson, it was needed, thank you.

MR THOMSON: I am obliged, my Lady, thank you.

Again, he is here today.

LADY SMITH: Thank you.

MR THOMSON: It is not proposed to repeat the earlier submissions beyond seeking their adoption as part of the submissions.

Some findings in fact. Significant numbers of school-age children suffered traumatic abuse whilst resident at schools and in the care of the De La Salle Brothers. Many of the children came from disadvantaged and challenging backgrounds. The lasting impact on the victims was palpable. Some have not spoken of their experiences for most of their lives. It was also clear from the evidence that family members have been deeply affected. The De La Salle Brothers failed the children who were abused. Those failings were systemic.

The failings could have been greatly lessened had

the care emphasis been more on listening and less on control. Though not the sole perpetrator, the actions of the unrepentant Michael Murphy should be recognised as particularly serious.

LADY SMITH: Yes.

MR THOMSON: Alongside the failings of the De La Salle Brothers, there were structural and systemic failings in the governance and oversight of the care of children by other stakeholders, particularly the managers.

Addendum response. The addendum document is adopted as part of this closing submission. The addendum discusses what can be taken from the available documentation concerning St Joseph's School, Tranent, and St Ninian's, Gartmore.

St Joseph's. Extensive records were retained by East Lothian Council. These include minutes of manager's meetings, daily logbooks, et cetera. The minutes and logbooks are comprehensive, extending over decades. The minutes assist with understanding the governance and management of the school. They also show the composition of the managers and that lay persons were generally in the majority at meetings. The clergy present were generally not the De La Salle Brothers, rather it was archdiocese clergy who attended along with the lay members and in later years the head, who was

a member of the De La Salle Brothers. The daily logbook shows regular visitors, such as psychologists, social workers, Her Majesty's Inspectors, et cetera.

St Ninian's. Unfortunately the surviving record keeping position is poorer than for St Joseph's. Stirling Council responded to a Freedom of Information request that they had no records. Further, police statements taken in 2000 indicate that many of the school records were destroyed on the instructions of the Scottish Office. The Inquiry has heard evidence that management meetings were held, and the Inquiry has also heard that the management structure was the same as at St Joseph's.

Closing comments. The De La Salle Brothers have engaged with the Inquiry in a manner consistent with the deeply held belief that the national public record on abuse should be as comprehensive as possible. Attention must be paid.

The De La Salle Brothers, of course, accept that they failed. Those failings were part of wider systemic failures by other parts of the care structure then in place. Points about the managers have already been made in the opening statement and closing submission.

The meaning of significant levels of abuse cannot be reduced to numbers alone. That the De La Salle Brothers

participated in the teaching and care of almost 9,000 school-age children does not reduce the significance of the numbers who gave evidence. The abuse they suffered, its repetition and the lack of belief they encountered when they reported abuse add to the significance of what occurred.

Though the De La Salle Brothers ceased to have a presence in Scotland in 1992, that has not and will not prevent it continuing to have close regard to lessons which can be learned from the Inquiry.

The International Lasallian Conference took place in Rome in 2024. At the conference, the De La Salle Brothers discussed the Scottish Child Abuse Inquiry. The Inquiry featured in lectures and in plenary sessions, the practical focus being on assisting the understanding and practices of safeguarding personnel who were involved in implementing standards and addressing abuse cases.

There is a safeguarding committee which includes experienced external professionals, who ensure that safeguarding policies meet proper expectations and support the safeguarding lead. The trustees of the De La Salle Brothers receive reports from the committee after each meeting, regular meetings are held with the safeguarding lead. All Brothers, staff and volunteers

are informed and educated about safeguarding by mandated training. The Brother Provincial and safeguarding lead collaborate with church safeguarding services and local authority designated officers in England and Wales.

The De La Salle Brothers have also used their experiences at the Inquiry when making contributions to the updating of safeguarding policies for the Catholic Church in England and Wales.

The De La Salle Brothers understand the need for eternal vigilance to listen to and understand the children in their care, to prevent abuse in all its forms by having proper systems in place, and to act quickly when any suspicions arise.

The lessons from the Inquiry are being utilised in the De La Salle Brothers' ongoing involvement in the education of children across the world.

LADY SMITH: I can see that's a significant point you make, Mr Thomson, although the De La Salles no longer have a presence in Scotland, they do have a presence in many other countries, do I have that right?

MR THOMSON: Indeed they have. Attention must be paid and action must be taken, and it is an inculcation into the ongoing DNA of this, if I can put it that way.

LADY SMITH: Thank you.

MR THOMSON: No part of the De La Salle Brothers remains

unaware. No part of the De La Salle Brothers remains unaltered by that awareness.

I am obliged, my Lady.

LADY SMITH: Thank you.

The Salesians.

MR THOMSON: I am obliged, my Lady.

LADY SMITH: We are turning now to their presence here in providing at St John Bosco School, is that right?

MR THOMSON: That is indeed, my Lady.

Closing submissions by Mr Thomson on behalf of the Salesians of Don Bosco

MR THOMSON: The Salesians of Don Bosco gave a full and unreserved apology to the victims of abuse in both their opening statement and their post-evidence submission. They do so again today.

They are grateful to the Inquiry for allowing them to play a part in creating a national public record of the historic child abuse of children in care in Scotland.

The Salesians of Don Bosco confirm their commitment to the aims and terms of reference of the Inquiry. They undertake to study and engage with all the Inquiry's findings. Since the evidence session, they have further engaged with the Inquiry and provided an addendum response to the closing statement made by the

Archdiocese of St Andrews & Edinburgh on 30 August 2024.

That addendum response was prepared in part by examining the extensive records the Salesians of Don Bosco have retained since St John Bosco School closed more than 40 years ago. These records had been provided to the Inquiry to assist in achieving as full an understanding as possible. The records include minutes of the managers' meetings from 1960 to 1983.

Again, it is not proposed to repeat the earlier submissions beyond seeking their adoption as part of this submission.

Findings in fact. The Salesians of Don Bosco failed children who suffered abuse whilst resident at St John Bosco School, Aberdour, Fife. Most of the children at the school came from disadvantaged and challenged backgrounds. In addition to the obvious suffering as children, the continuing impact on them as adults and the lasting effect upon their families was readily apparent in the descriptions of living with the effects of abuse.

The failings could have been greatly lessened had the care of the children stayed close to the preventative system advocated by Don Bosco and developed over the years. Accompanying the failings of the Salesians of Don Bosco were structural and systemic

failings in governance and oversight of the care of children at St John Bosco School by stakeholders such as the managers and others.

Addendum response. Consequent upon the closing submission made by the Archdiocese of St Andrews & Edinburgh, the Salesians of Don Bosco provided an addendum response to the Inquiry. That addendum is adopted as part of this closing submission.

LADY SMITH: Yes, thank you, also for that addendum. Again, it was needed. I am grateful for it, thank you Mr Thomson.

MR THOMSON: During the closing submissions of the archdiocese 30 August 2024, it was stated that the archdiocese had no involvement in the Board of Managers at St John Bosco School. The minutes of the meeting of the managers provided to the Inquiry disclose that the archdiocese was involved.

In 1964, the Vicar General of the St Andrews and Edinburgh Archdiocese approved in principle the setting up of a Board of Managers.

In 1965, the Archbishop gave permission for the establishment of the St John Bosco School on a permanent basis. Clergy of the archdiocese were managers and sat on the Board of Managers, which met regularly.

Closing comments. The Salesians of Don Bosco accept

that there were serious failings and shortcomings on its part. They have engaged with the Inquiry in a full and transparent manner. They understand the importance of making the national public record on abuse of children as comprehensive as possible. The evidence sessions disclosed serious abuse. In the absence of failings and shortcomings, abuse could have been prevented. The failings were part of wider systemic failures by other stakeholders who formed part of the care structure then in place. Comments about the managers have already been made.

The Salesians of Don Bosco set out to do as much good work as was possible for the children who attended St John Bosco School. That much of this aim has been thwarted by failings and shortcomings is a matter of intensive and reflective regret to them. Some applicants had positive memories of the school, this does not detract from the suffering of those who had negative memories.

That the Salesians of Don Bosco ceased to have a presence in Scotland in 1983 will not prevent it continuing to have close regard to the lessons which can be learned from the Inquiry and utilised in its ongoing involvement in the education of children across the world.

Those lessons include the need for eternal vigilance to listen to and understand the children in their care, to prevent abuse in all its forms by having proper systems in place and to act quickly when any suspicions arise.

Even though worldwide regulation and oversight has increased significantly since 1983, the Salesians of Don Bosco have sought to ensure that the lessons they have learned from this Inquiry's scrutiny of abuse at St John Bosco School inform the policies and practice of the wider congregation, through reports, discussions and meetings.

I am obliged, my Lady.

LADY SMITH: Thank you very much, Mr Thomson.

If I could now turn to Mr Watson.

Mr Watson, I know you represent two different councils, East Lothian and South Lanarkshire, if it would work for you we would hear from you about East Lothian first.

Closing submissions by Mr Watson on behalf of East Lothian Council

MR WATSON: Yes, thank you, my Lady.

Your Ladyship will recall from previous phases and from the opening statement for East Lothian Council that they were formed on the disaggregation of Lothian

Regional Council in 1996.

My Lady, a consequence of that is that management of St Joseph's School transferred to them in 1996, and they were then responsible for closing it in 1998. As a consequence, their involvement was effectively limited to oversight of its closure.

There has been no similar establishment in East Lothian since then, but, of course, they remain responsible for the care of children in care and in other settings throughout their area.

My Lady, the council has therefore taken this Inquiry and this phase in particular as an opportunity to understand where there have been past failures, how other councils have dealt with and responded to those and where they can be developing and continually improving their own care of children.

My Lady, Lindsey Byrne, Head of Children's Services and Chief Social Work Officer, or Emma Clater, Service Manager for Children's Services, and sometimes both, were present via WebEx for all of the evidence relating to St Joseph's and Ms Byrne is present in person today.

LADY SMITH: Thank you.

MR WATSON: Your Ladyship has heard the closing statement for the council at the end of Chapter 2, and I would adopt that today.

But given the council's limited involvement it is perhaps of more utility to look at the themes emerging, and, through that, specific areas where the council has taken action in response to this Inquiry, and where further development is ongoing. Let me address three specific areas of development, my Lady. The first of those being record keeping.

Following the Inquiry, and following on from what I said on the last occasion, the council has worked to be increasingly aware of, and sensitive to, the content and audience for social work files. They may be serving a particular professional purpose now, but they will be read by children and young people in the future. These are files that are produced or held by East Lothian Council, but in a real sense belong to the child or young person. That awareness and practice of drafting with deliberate intention is how they are working to shape good practice on record keeping, and on more formal report drafting now.

My Lady, they have required staff to undertake training that is focused on the language they used, they use in discussion or in recording information about children, young people and their families. Staff who have completed this training have found it helpful with positive feedback from the latest cohort of 22 from

residential settings. They have also been listening to their children and young people in improving their processes, for example using the term 'care experienced' rather that the acronym LAAC, looked after and accommodated children.

LADY SMITH: If I may say, that is an enlightened and very easy move. The average person reading a file later on won't have a clue what acronyms stand for.

MR WATSON: No, indeed, and over the passage of time acronyms change so quickly.

LADY SMITH: I think we all have difficulty with that.

Thank you.

MR WATSON: My Lady, they are also hosting training and refresher sessions on trauma-informed practice across the council, recognising that children and young people with complex family situations can interact with the council in a number of ways.

Although this Inquiry focuses on residential settings, similar issues can arise through schools and for those who provide support on housing issues, amongst others.

They are embedding trauma-informed vocabulary in their templates and records, ensuring the young person remains at the centre of those with some documents now being drafted as if they were addressing the child, even

when the child is not the immediate recipient.

The council has challenged their practitioners to reconsider how behaviour is viewed, understanding that this is a form of communication for children and young people that can offer insight into the challenges and stresses young people are facing. My Lady, one of the witnesses put it as:

'Hurt people hurt people.'

LADY SMITH: Yes.

MR WATSON: These updated practices are now subject to multi-layered review and scrutiny, with not only team managers supporting on constant improvements, but their senior managers, and the chief social work officer, ensuring that case files demonstrate improving practice. These discussions take place at team meetings, supervisions, more formal file audits and staff performance reviews. So it is at all levels, my Lady.

LADY SMITH: Yes.

MR WATSON: The council recognises that this is a process of continuous improvement and that the child's voice is as essential as active, effective support and training for staff. The council takes its best practice goals extremely seriously and will continue to challenge their templates, processes and skills to refine their practice through formal and informal means.

This is one concrete example of the council being a strength and skill set based and outcome-focused service, supporting and modelling behaviour and best practice.

Let me just say exactly what that means, my Lady: it means that the council focuses on the strengths and skill sets that their service users and families do possess and work with them to use and empower them to use those. They encourage taking a positive outlook rather than focusing on what strengths or skills might be missing.

LADY SMITH: Yes.

MR WATSON: Let me turn from record keeping of itself to explanations to and inclusion of children. My Lady, one theme from this phase and others has been the striking lack of space for the voice of the child with those who are caring for them, with the broader council or care organisation and with any independent advocate. East Lothian Council has been addressing that over many years and again I said something of that on the last occasion, but in the intervening months that has continued.

The council's practice model promotes the central consideration of all information being shared in a child friendly and accessible way, be that in outlining a current situation or for future planning. The council

is committed to information being accessible for every child, whether that's a word and pictures version of information or the need for a meeting to help support a child or young person to understand their situation, and for the plan for them.

LADY SMITH: Yes.

MR WATSON: My Lady, the child's view remains at the heart of all plans. That's embedded in their promise to keeping The Promise across all aspects of planning reviews and interaction with children, including children's hearing and child's plan review meetings. All files and practices are again subject to independent internal review by independent practitioners to quality assure cases at every stage.

The council is also committed to ensuring that every child or young person has access to bespoke advocacy services to promote their rights, needs and views. Currently every child with a looked-after and accommodated status, or those who are invited to children's hearings, are automatically referred to independent advocacy providers. East Lothian Council are additionally working on extending this offer of support to all children and young people who have contact with East Lothian social workers.

Finally, my Lady, may I turn to subject access

requests. Your Ladyship may recall that on the last occasion there was one former resident who had sought his records. They were not available, save for one logbook entry, and his experience of the process was of not having been assisted at all. The council has continued to review how they can improve that picture for those in care. The council must acknowledge that they operate with a variety of legacy systems and practices which present particular challenges, and, as your Ladyship is aware, many records are simply unavailable.

LADY SMITH: Yes.

MR WATSON: The council does regret this, and it is a real source of frustration for them and they understand how difficult that must be for a child looking for information which is not held. They do remain committed to ensuring that any interactions with individuals are open, frank and transparent. Again, taking a trauma-informed approach. That means providing full and accessible explanations on why information can't be provided, and ensuring individuals are appropriately supported through those interactions.

That includes consideration of whether follow-up meetings, in person or online, would assist in them understanding the response, the information that has

been provided, or next steps in their circumstances.

The council is also exploring providing additional information such as general information about schools or practices at the relevant times as a way of helping them to understand their own circumstances, either to supplement information that has been available, or in place of information that is not.

This is another area where the council is committed to continuous improvement and keeping the child at the centre of their process and practice. It is a reality that they will not always be able to provide the information sought, but the outcome can be delivered in a compassionate and accessible way, ensuring full understanding of the limits of assistance and the supports they can offer.

Finally, my Lady, the council has asked me to read their distillation of the hugely significant impact their involvement in the Inquiry has had on them:

'The work of this Inquiry has been invaluable. The findings, evidence and information has fundamentally altered the way practitioners think about all aspects of the support we offer to children, from our day-to-day interactions with children, young people and their families, to the way we make decisions and record information. We will continue to improve how we work,

and the impact that has on the lives of our children and young people and their families.'

LADY SMITH: Thank you, Mr Watson.

Whenever you are ready, do feel free to move on to South Lanarkshire Council.

Closing submissions by Mr Watson on behalf of South Lanarkshire Council

MR WATSON: I am obliged, my Lady, I do indeed appear on behalf of South Lanarkshire Council, and also present today is Liam Purdie, who is Chief Social Work Officer and Head of Children and Justice Services for South Lanarkshire Council.

He was also present to hear the applicant evidence relating to Calder House --

LADY SMITH: I remember that, yes.

MR WATSON: -- and indeed South Lanarkshire Council's involvement does relate solely to Calder House.

LADY SMITH: To Calder House.

MR WATSON: Again, your Ladyship will be familiar with the process of aggregation and disaggregation.

The council became responsible for Calder House in 1996, through to its closure in 2007 and demolition in 2012. Your Ladyship has the closing statement I made at the end of Chapter 7, and again I won't repeat any of that, but I invite your Ladyship to include it as part

of this submission.

Let me turn to specific findings in fact your Ladyship may continue.

First, that there was endemic abusive practice at Calder House Assessment Centre. That this was directed, overseen and encouraged by the leadership at Calder House. That there was inappropriate punishment of children; scrubbing, detention cells, distressing delousing, no phone calls, long runs, restriction of clothing, premeditated and calculated approaches to disrupt their evenings. That there were forced strip searches by male staff. That children were inappropriately restrained by members of staff. That there was sexually inappropriate touching of girls. That there was collective punishment of children for minor infractions. That staff had established an inappropriate regime of punishment and reward. That there were inappropriate attitudes to children and offensive and abusive language used directly and in the records and that there was a failure of oversight by the council to recruit, train, supervise and oversee suitably skilled and caring staff, a failure to adopt appropriate formal and informal means of monitoring the care provided and a failure to provide children with any effective means of voicing their concerns, experience

and abuse outside Calder House.

My Lady, the previous closing statement sets out in more detail where the evidence came for those findings and I would invite your Ladyship to take that into account.

Let me use Mr Purdie's words to summarise the care provided:

'It was abusive and it was criminal. It was not child centred in any manner or means.'

My Lady, let me turn from findings of fact to acceptance of failures. As I have set out, the council accepts that there was abuse at Calder House, and as Mr Purdie said in his evidence, the council accepts that this was systemic, probably from its opening, and then throughout its operation.

The council accepts that they failed to prevent abuse occurring and more than that, they failed to have in place care for children that supported and nurtured them. South Lanarkshire Council apologises for that. They apologise to each child who suffered abuse, to each who was not listened to, to each who was not nurtured and to each family that suffered in consequence.

Let me set out some specifics of that failure, aside from the pivotal failure to prevent the abuse.

First, the culture at Calder House was in no way

child centred. It was not focused on the best interests of the children. There was little warmth or understanding from any of the staff as to what those needs were. That culture and practice was directed and endorsed from the top down at Calder House. The culture and the care regime was systemic and endemic.

Secondly, record keeping. This relied largely on logbooks which were staff centred. They were used as an offload for staff members to vent about a young person, often in derogatory terms.

LADY SMITH: That's a very important point, you have touched on it already, Mr Watson, but if staff let themselves think in derogatory terms and write in derogatory terms, they are going to be a long way from ever establishing a culture of respect for the children and understanding why the children behaved in a way that is difficult to deal with. Nobody's suggesting it is not, but if you, from the beginning, are allowed to assume that it is okay to be rude about the children, and regard them as thorns in your flesh, you are never going to establish a healthy culture that the children are going to be properly protected in.

MR WATSON: Indeed, my Lady.

As I think I said on the last occasion, if that was what they were writing down, goodness knows what they

were saying in person.

LADY SMITH: Indeed, yes.

MR WATSON: I will return to that, my Lady, in addressing how the council has moved on.

LADY SMITH: Mm-hm.

MR WATSON: One aspect was that records tended to deal with a number of children across the home rather than maintaining individual records for individual children. There was no understanding of their needs, the trauma they may be going through, or why a child would be upset. There was a lack of specificity and detail in records. There were no occurrence sheets, perhaps to hide further punishment, or other incidents. The tone betrayed an attitude of disrespect and carelessness towards the children for whom they ought to have been caring.

Thirdly, and finally, recruitment and training. There was little evidence of safe recruitment practices or how staff were trained, equipped and kept up to date. The Council has radically altered their approach in the intervening years, as your Ladyship has heard, and they accept that they failed to have appropriate measures in place at that time.

Let me turn to addressing the identified failures.

My Lady, I will start with the most striking

example, the evidence from 'Jessica', regarding the sexual abuse of another child by a staff member. Aside from the steps that have been taken to prevent such an incident occurring, if that were to be reported now the allegation would trigger a joint police-social work investigation.

Let me turn to safe recruitment. Staff are appropriately vetted and will have appropriate qualifications. In addition to qualifications and experience, however, they also want the right attitude and motivation. As Mr Purdie said:

'We are looking for people who are child centred. We want people that can actually engage and form a relationship with children and primarily someone who likes children.'

They are ensuring that children and those with experience within South Lanarkshire's care system are involved in the interview process. There is a soft interview, not scored, an informal conversation when children in care have a conversation with the candidate and share their views with the interview panel about who their preferred candidate would be. Champions Board and Promise workers employed by the council and who are care experienced are involved in the interview process. They provide their view of what is a child-centred worker.

LADY SMITH: I may have asked this at the time, forgive me if I did and I have forgotten. The use of this word 'Champions', have you any idea what it emerged from and why it was felt to be the right description?

MR WATSON: I can't say that I do, my Lady, and I am not going to extemporise, but I can come back to your Ladyship on that point after this.

LADY SMITH: It is not a hugely important point, but I have wondered whether it is the right way to capture what is good work, evidently, on the part of the council in its involvement with children and young people.

MR WATSON: Yes, my Lady, and I will come back to your Ladyship on that.

LADY SMITH: Thank you.

MR WATSON: My Lady, staffing ratios are now sufficient to stop staff ever being alone with a child in a room. There should always be two members of staff. This is protective of children and supportive of staff. There should always be a log, including a record of who entered the room, and when, and why, and who was with them. And that log is routinely checked.

That is coupled with offset shift patterns so that there is not always the same two individuals on shift together. That avoids conscious and subconscious collusion between staff. It reduces the risk of undue

influence between experienced and inexperienced practitioners.

That leads on to supervision. One-to-one supervision takes place with an employee and their supervisor to help maintain a culture where colleagues comply with the protocols and can report non-compliance of other staff. If an employee was uncomfortable about a peer's practice, that should be an opportunity to share it.

In addition, there are ongoing constant informal opportunities for supervision. It can be a sense check by the line manager or supervisor. They are trained to be inquisitive about what took place on a shift.

The council has also provided the opportunity for all staff to speak to a more senior member of staff outwith their formal supervision arrangements. They are encouraged to do so if there is anything they are uncomfortable with. The council has implemented a duty to report any concerns arising from a staff member's care of children. This is now made clear in their induction and in child protection training. It is their duty to report concerns. There would be a consequence for not raising a concern. This is viewed as a breach of their contract, as well as a breach of that duty, and would result in a fact-finding investigation. The

sanction of dismissal or management action is available.

LADY SMITH: The duty is actually written into the contract of employment now, isn't it?

MR WATSON: It is, my Lady, yes.

LADY SMITH: Yes.

MR WATSON: In addition, after all that, if staff members are not confident in sharing concerns, the council has a confidential disclosure line which can also be anonymous, similar to a whistleblowing structure. If a confidential concern is raised, an investigation is triggered. The council would always advocate transparency and openness and wants a culture where staff are comfortable and confident to report concerns directly, but this adds an additional layer of support. Where there are anonymous disclosures, the council will then focus on establishing facts before considering how to address it.

My Lady, I have already touched on record keeping and that has been significantly overhauled. Mr Purdie set out how they want to move to one file for each child, held electronically, which will also have access to their full electronic system, and is transparent for all care providers. Any event relevant to that child, including, in fact perhaps particularly, the positives from their day can be added to that file. Aside from

assisting those providing care at that point, it will be a much fuller record for the child in the future.

Staff are trained on appropriate language to use. Residential staff can go directly onto the file and record anything within that, including the child's journey, not just negative behaviour. It should be more like a daily diary.

Staff are now trained in trauma-informed approaches to childcare. The council currently has a programme in place which provides training on trauma-informed practice which all staff and foster carers are expected to complete. This involves training around recognising the impact of trauma, how children respond and how to respond appropriately when there are triggers that would set off that trauma. There is external psychological therapy available for staff. A psychologist provides group and individual reflections for residential workers and advice on how to cope with vicarious trauma when dealing with young people. That psychologist also acts as an external pair of eyes on how they support staff to deal with young people and their trauma.

The council also now encourages social workers to undertake announced and unannounced visits in all types of accommodations. They must be clear about the purpose of a visit. Just seeing a child in an interviewing area

is not appropriate. They should make sure that they have a sense of the full care setting, and the opportunity to speak to the child without them being influenced by what is said by staff or other children.

Finally, my Lady, discipline and restraint. The council has adopted the Therapeutic Crisis Intervention approach to care, flowing from the 'Holding Safely' report. They adopt promoting positive behaviour as a strategy for working with children in care, viewing restraint or physical contact as a last resort, working on how to recognise triggers and use different strategies. All residential workers are trained in that framework. Any new staff are not allowed to be involved in restraint or, indeed, any diversion activity before completing the course. Where restraint does take place, it requires a debrief and report. If a diversion strategy is used, again a report is prepared to show why a restraint was not needed.

My Lady, and more briefly, there are ongoing areas for improvement. The council has recently published a new social work management system and this will be rolled out to all current children's homes registered in the council area. This will enable all residential staff to input directly to the child's file. This can then be seen in real time remotely by the social worker

and relevant managers involved in the child's care plan.

In his evidence, Mr Purdie noted that there are resource challenges, and that remains the case. It is challenging to meet the goals of The Promise with current levels of recruitment and resourcing. The Council is engaging with the Independent Care Review, but the biggest challenge at present is the recruitment and retention of care workers, with many burning out after a few years.

The council also knows there is more to do on maximising the voice of the child. They are investigating giving children the opportunity to request a visit from an independent advocacy service, how that would be accessed, who would provide it and how it would dovetail with other care providers. They are also looking at developing an app as an additional means of children requesting the opportunity to speak to their social worker.

The council is developing further external oversight of the management of homes. An external manager should have visibility within the children's houses and should make a routine record of those visits in a more systematic way. That should evidence their visibility, and provide external eyes on the culture within a house. They will meet the registered manager, varying meetings

between the home and council headquarters. They will develop a relationship with staff and with children, so that they can be a part of the call for raising concerns, as well as observing care provision in action.

To provide an additional scrutiny of activity, South Lanarkshire Council has also agreed that their child protection committee should receive an annual report from a relevant senior manager to report on activity from complaints, investigations, inspections, advocacy and significant events within children's houses across South Lanarkshire. This will give additional scrutiny and challenge in relation to and assist in ensuring safe practice and standards for children across all South Lanarkshire children's houses.

My Lady, South Lanarkshire Council wants to repeat their apology to those children who suffered the abusive regime in place at Calder House and it was an abusive regime, unchecked by proper oversight, and the council apologises for that.

As a result of this Inquiry, they have reflected on how, as a council and as a profession, they have let children down. The areas of improvement I have set out will be implemented and reviewed on an ongoing basis. The conclusions of this Inquiry will be shared across the service. Any actions will be implemented in

an improvement plan. They will ensure that there is elected member scrutiny of this through appropriate council and social work committees.

The Chief Social Work Officer, who is here today, has asked that I give this commitment from him personally and on behalf of the council as a whole.

LADY SMITH: Thank you very much, Mr Watson.

I am very grateful for that, and also for the details of where South Lanarkshire have now got to in the improvement and development of their child protection practices in particular, and overall their services to children who have to be in residential care.

It does look as though they know that that work is never done and that's good to hear.

MR WATSON: Yes, absolutely, my Lady.

LADY SMITH: Thank you.

Could I now move on to Mr Henry.

Mr Henry, I know you are here wearing a number of hats, and no doubt the first you would like to cover is the Archdiocese of Glasgow, is that right?

Closing submissions by Mr Henry on behalf of the Archdiocese of Glasgow

MR HENRY: It is indeed, my Lady, thank you.

My Lady, I do indeed appear on behalf of the Roman Catholic Archdiocese of Glasgow. The archdiocese traces

its post-Reformation history to 1878 and the current archbishop is the Most Reverend William Nolan, who was installed as Archbishop of Glasgow on 26 February 2022.

The archdiocese accepts that harm was caused to children, who are now adults, as a result of their time in residential accommodation. The archdiocese acknowledges the suffering, trauma and pain survivors have experienced and their bravery in coming forward. The archdiocese acknowledges that there will be others who have suffered but have not come forward.

The archdiocese deeply regrets that abuse has taken place and apologises for any failings on its part which have in any way contributed to that abuse and the archdiocese continues to seek ways to support survivors.

In Phase 8 the Inquiry heard evidence in relation to a number of establishments, but of particular interest to the archdiocese are St Mary's Kenmure, St Andrew's Shandon, St John's Springboig, St Ninian's Gartmore, St Mungo's Mauchline and the Good Shepherd Centre in Bishopton.

Dealing first, my Lady, with St Mary's Kenmure. As the Inquiry is aware, the school was placed under the superintendence of the De La Salle Brothers in 1916, but the property itself remained in the ownership of the archdiocese. The archdiocese appointed some members of

the Board of Management, with others being appointed by the Town Council of Glasgow. The Brother Superintendent who was the headmaster of the school was appointed by the Superior General of the Brothers, as were other Brothers. Lay staff were appointed by the superintendent, but the chaplain of the school was appointed by the archbishop.

The Board of Management did include at times representatives from other local authorities, and at some point the board took on the employment of the staff and the Brothers, though the archbishop appointed the chaplain of the school. When the De La Salle Brothers left the school in 1966, the board of the school continued as it had done before, employing staff as required.

The Board of Managers was responsible for the school and employed the staff. The archbishop appointed the board members. These board members appointed included clergy from the archdiocese. The board members were appointed to assume membership of the board and to assume responsibility for the establishment. They employed the staff at the school and governed it.

There is of course evidence before the Inquiry, both in relation to the historical position at St Mary's Kenmure and the current difficulties faced by the

school.

LADY SMITH: Yes.

MR HENRY: Throughout this time, the archdiocese appointed board members and clergy from the archdiocese were at times appointed as board members.

For St Andrew's Shandon, my Lady, the archdiocese holds very little material in relation to that school, which closed in 1986.

When the school opened in the mid-1960s, the property was transferred to the trustees of the managers of the school, before being transferred to the headmaster of the school, again, my Lady, as was, I think, previously identified presumably in his official capacity rather than a personal transfer.

The school was run under the auspices of the church and in particular the archdiocese. The archdiocese nominated board members, as well as local authorities nominating board members, and the archdiocese was represented on the board, although it was led on a day-to-day basis by the headmaster.

For St John's Springboig, the archdiocese appointed the Board of Management of that school, the Board of Management employed the staff of this school, including the De La Salle Brothers. At least some of the time, some local authorities nominated members of the board of

managers.

St Ninian's Gartmore was not within the geographical Archdiocese of Glasgow. The archdiocese did, however, own the school buildings and appointed the board of management. The Board of Management was autonomous and employed the staff, including the Brothers. The Brothers operated the school on a day-to-day basis, and one of them served as headmaster though the archdiocese did provide resident chaplains to the institutions, at least from 1946 to 1968.

Although there are no reports of chaplains after 1968, my Lady, it is likely that some chaplaincy service was provided.

LADY SMITH: Mm-hm.

MR HENRY: The archdiocese has records of two priests serving as chaplains of St Mungo's between 1942 and 1956.

My Lady, turning to the Good Shepherd Centre. In the late 1940s the Good Shepherd Sisters began the process of removing themselves from the east end of Glasgow and moving to Bishopton in Renfrewshire. Bishopton is currently located within the Diocese of Paisley. However, my Lady, from 1878 until 1948, Paisley was part of the Archdiocese of Glasgow, before being established as a separate diocese in 1948.

In the early 1980s, the Sisters began the process of removing themselves from Bishopton.

In April 1981, the then Archbishop of Glasgow, Thomas Winning, wrote to the convent's solicitor, indicating that the bishops were ready to undertake the responsibility of running what was then the St Euphrasia's Centre for a period of two years. The responsible body became the Scottish Hierarchy of the Church.

During this time, a Board of Management was established and took responsibility for the governance of the school. The archdiocese understands that the structure of the board has been changed to a company limited by guarantee and remains a charity.

With its location within the Diocese of Paisley, the archdiocese understands that the responsibility for the appointment of the board lies with the Bishop of Paisley. While there was a period when, in terms of articles of association, the archdiocese had some rights in terms of appointments, it is understood that in practice appointments were made by the Bishop of Paisley. There have, however, been periods where clergy from the archdiocese were members of the board.

Throughout the course of this phase of the Inquiry, the Inquiry has heard evidence of abuse, including

evidence of physical, sexual and emotional abuse. There is evidence of home leave being withdrawn as a punishment. There is evidence of controlled drugs being brought into St Mary's by staff. Regardless of whether the day-to-day operations of schools were being run by the De La Salle Brothers or lay staff, Boards of Managers were responsible for managing the schools in the interests of the welfare, development and rehabilitation of the children. The archdiocese accepts that through those board members, it ought to have been aware of the way in which schools were being run, and that it had the right to influence the way in which those schools were being run.

The archdiocese accepts that whatever rules, regulations, legislation, policies or procedures that were in place, they failed to prevent the abuse described by the survivors. The abuse described by the survivors happened while Boards of Management were in place. The archdiocese regrets this and apologises for any failings on its part that may have contributed to that abuse.

My Lady, as I indicated earlier, the Inquiry has also heard evidence in relation to the current difficulties faced by St Mary's Kenmure. The archdiocese regrets that failings on its part may have

contributed to that situation which is faced by St Mary's, and, most importantly, the children cared for there, and the archdiocese again apologises for any failings.

Throughout the course of this phase of the Inquiry, the archdiocese did not seek to question survivors, it does not seek in any way to challenge or minimise the experience and evidence of the survivors of what happened to them when they were children. The archdiocese is committed to learning lessons through this Inquiry.

My Lady, the archdiocese is a component of the Bishop's Conference of Scotland's view of a one of all church approach to safeguarding. The archdiocese has been involved in the review of safeguardings at all levels within the church in Scotland. This review led to the development of a Scotland-wide safeguarding manual, 'In God's Image'. This was reviewed and updated after three years and is now on its second version, which came into effect on 8 September 2021. The archdiocese works within the safeguarding standards set out in that document. Each diocese advises the Bishop's Conference of Scotland of any changes in practice or procedure in order that the safeguarding manual is kept up to date and that all diocese are alerted to any

amendments.

As part of the archdiocese's adherence to safeguarding, there is training for all, including clergy, employees and volunteers within the church. A fundamental part of that training is the church-wide policy of mandatory reporting of abuse. If abuse is seen, or there is a disclosure of abuse, whether that is said to have occurred within church settings or elsewhere, the diocesan safeguarding adviser is informed.

The archdiocese follows the policy of mandatory reporting, requiring all allegations of abuse to be reported to police. The archdiocese is monitored by the Scottish Catholic Safeguarding Standards Agency, which is an independent body.

LADY SMITH: Yes.

MR HENRY: As outlined previously, my Lady, the archdiocese accepts that harm was caused to children, who are now adults, as a result of their time in residential accommodation. It acknowledges the suffering that they have experienced, and apologises for the failings on its part which have contributed to that suffering.

LADY SMITH: Thank you.

Where do you want to go next, Mr Henry?

MR HENRY: My Lady, I understand I was simply taking the

order that was in front of me, my Lady. I would move to St Philip's, unless your Ladyship wishes otherwise.

LADY SMITH: Thank you very much, yes, thank you.

Closing submissions by Mr Henry on behalf of St Philip's School

MR HENRY: My Lady, I appear on behalf of St Philip's School, which is located within Plains in North Lanarkshire.

It was initially created as an approved school, opening in 1970. It is a specialised educational and residential centre, that primarily serves children and young people with additional support needs.

The school is a Catholic independent school, providing care and education in the residential setting. It is part of the residential school sector in Scotland, offering both residential care and day placements for its pupils. The school typically caters to pupils with social, emotional and behavioural difficulties, as well as those with other complex needs. The school supports those who may have experienced significant trauma, attachment disorders or other psychological and emotional challenges, and who may require specialised support that mainstream schools cannot provide.

The school also takes in pupils with learning difficulties, autism spectrum disorders, and other

additional support needs that require a tailored educational approach.

My Lady, following the closure of a secure unit at St Philip's in 2011, the school moved from the then main campus and relocated to within that secure unit building. Following a programme of environmental upgrade and development, the former secure unit was decommissioned and registered as a school care accommodation service. Although the school is now a company limited by guarantee, it is managed by an independent charitable organisation. A Board of Directors oversees the school's operation. The management structure of the school includes a director of services, who is responsible for the day-to-day running of the school. The director is supported by a team of senior staff, which include a deputy director, senior service managers, residential care managers, assistant managers and specialised teachers.

The operation of the school is focused on providing a safe and nurturing environment that promotes both educational and personal development. The management aims to ensure that all staff members are trained to handle the specific needs of pupils, including therapeutic support, specialised teaching strategies and behavioural intervention.

St Philip's School notes that the definition of 'abuse' is wide ranging and can manifest itself in many forms. It acknowledges that abuse took place within the school. The school recognises the bravery of the survivors who have given evidence to the Inquiry, but it recognises that there will be others who have not yet come forward.

The school apologises for the abuse suffered by children, and the pain and suffering that this has caused. The school did not seek to question or challenge the evidence of the survivors in any way, and the school considers that it is for your Ladyship to make any findings in fact that she sees fit.

My Lady, the evidence which was led relating to St Philip's School prior to 1990 is of a school which was far different to the one which emerged from that time and beyond. The Inquiry heard evidence from Mr Patrick Hanrahan, who was headmaster of the school from 1990 to 2009, and Mr Brian Harold, who was a depute head of the school from 1989 until he replaced Mr Hanrahan as headmaster. Mr Hanrahan's evidence was that his initial impression of the school was not good, that in the main there were good people trying do their best in sometimes very difficult circumstances, and that people were open to change, wanted to learn, but needed

a lot of guidance.

Mr Hanrahan's evidence was that the leadership team at the school prior to his recruitment was unsatisfactory. He also stated that some of the older staff members employed by the school had what he termed outdated practices and skills.

Mr Harold gave evidence that he viewed Mr Hanrahan's arrival as the catalyst for change. Mr Harold discussed working together with Mr Hanrahan and, indeed, the wider management team to better the culture within the school, and to try and improve the standards and quality of care, whilst providing children with a voice so they could be heard and listened to.

It is submitted that the arrival of Mr Harold and Mr Hanrahan was indeed a positive move for all involved at St Philip's, including the children in its care. Whilst prior to Mr Harold's arrival there was what would be described as a fairly basic system, where children were dealt with by staff as best they could, and, indeed, if things got out of hand the children would be restrained, Mr Hanrahan's position was that the policies and practices relating to the restraint of children were routinely being monitored and reviewed as part of a wider process to change the school for the better.

Survivors from St Philip's gave evidence of home

leave being taken away from them as a form of punishment. The school accepts that the use of the removal of home leave as a form of punishment was inappropriate and unacceptable. It apologises for all instances in which it was used as such.

St Philip's School is dedicated to continually learning and improving its services for and care given to children who enter the school. It is guided by current legislation and guidance, including the incorporation of the UN Convention on the Rights of the Child, the Independent Care Review from 2020 and the recommendations set out in The Promise. In line with this, structures are in place to allow children's voices to be heard and they are encouraged to participate in decision making concerning their care.

There is now a strengthened independent oversight of residential care which increases accountability. St Philip's is subject to inspection by the Care Inspectorate and Education Scotland. Child safeguarding and the upholding of children's rights is a key focus of all inspections.

The local authorities, who place children into St Philip's, carry out regular monitoring visits and request updates from the school. In addition, Police Scotland carry out a monthly monitoring meeting

to support the care of children.

St Philip's School considers that properly trained and qualified staff are key to any safe and effective system of work and care. All staff are provided with training and the school's learning and development service ensure that staff receive child protection training. The school has identified safeguarding leads across the organisation to ensure that children are protected and consistently supported by staff.

St Philip's now has its own human resources department, which ensures that the recruitment of staff adheres to the safer staff recruitment policy and the PVG scheme. Within the school, practice development meetings take place on a monthly basis, or more frequently if required. These meeting have a focus on safeguarding and are attended by identified safeguarding leads, as well as a range of staff from across the organisation.

Children in St Philip's, as well as staff members, can access psychological service support and, through a partnership with the NHS, have access to services including mental health support and counselling. These services are part of attempts to foster a culture at the school, which prioritises children's rights and well-being. This has led to the school gaining

the Nurture Schools Award, it has been awarded Employment Charter from North Lanarkshire Council and all staff members complete Therapeutic Crisis Intervention 7 training and trauma-informed practices to support young people.

LADY SMITH: Who awards the Nurture Schools Award, Mr Henry, do you know?

MR HENRY: If your Ladyship would allow me one moment.

LADY SMITH: Thank you.

(Pause)

MR HENRY: My Lady, I certainly don't have that information to hand, unfortunately.

LADY SMITH: Well, you can let me know when you find out, thank you.

MR HENRY: Indeed, my Lady.

My Lady, as I indicated, the Therapeutic Crisis Intervention 7 training and trauma-informed practice is offered to all staff members, to allow them to support young people to manage their emotions in a therapeutic way and the staff receive refresher training on this on a six monthly basis.

My Lady, these changes have not been set out to create an impression that St Philip's is in its current guise perfect or that new and better ideas and practices will not emerge. The school considers that lessons can

always be learned and practices always improved. It is hoped that by listening to the most important voices at the school, those of the children, that the school can continue on its path of improvement and provide children with the level of care that they deserve.

LADY SMITH: Thank you very much.

I am just wondering, Mr Henry, whether I should break now and you can pick up with St Mary's Kenmure and the Good Shepherd at 2 o'clock.

MR HENRY: Certainly.

LADY SMITH: Rather than have you rush through St Mary's, because there are some significant things, obviously, you will want to say about St Mary's in particular.

MR HENRY: Indeed, my Lady.

LADY SMITH: I will stop now for the lunch break and sit again at 2 o'clock.

Thank you.

(12.55 pm)

(The luncheon adjournment)

(2.00 pm)

LADY SMITH: Welcome back.

Mr Henry, I think we were about to go to St Mary's, is that correct?

Closing submissions by Mr Henry on behalf of St Mary's Kenmure

MR HENRY: It is, my Lady, thank you.

My Lady, I appear on behalf of St Mary's Kenmure.

My Lady, St Mary's Kenmure accepts that survivors who were children were harmed as a result of their time at the school and it apologises for those failings which contributed to that pain and suffering.

My Lady, St Mary's Kenmure is located in Bishopbriggs, East Dunbartonshire. While it can trace its roots back to the east end of Glasgow in the mid 19th century, in or around 1905 the school moved to the Kenmure Estate in Bishopbriggs.

In 1916, following a minute of agreement between the Chairman of the Directors of the Catholic Industrial School of Glasgow and the Superior General of the De La Salle Brothers, the school was placed under the superintendence of the Brothers.

The De La Salle Brothers provided key employees, and, with other staff, ran the school until they left in 1966. Following the Brothers' departure, the Board of Management governed the school and employed staff.

In the mid 1970s, a secure unit known as the Ogilvie Wing was opened on the site. A new secure unit was subsequently built on the site, opening in June 2000.

It was registered for 36 beds, plus one emergency bed. At the time, St Mary's Kenmure provided six open places and 30 secure places.

Prior to the opening of the new secure unit, the Archdiocese of Glasgow sold the site to the Cora Foundation. The board of management continued as before and when the new building opened and the children on the site had moved into the new secure unit, the predecessor buildings were either demolished or to be demolished. The secure unit, or the former secure unit, is now the only building on the site.

While St Mary's Kenmure is a company limited by guarantee, it is managed by an independent charitable organisation. A Board of Directors oversees the operations, and a head of services is responsible for the day-to-day running of the school. The company is the registered provider of services to young people and is registered with the Care Inspectorate and the Registrar of Independent Schools. It is approved by the Scottish Ministers to provide secure accommodation services.

The objects of the charity are to provide secure care and education for young people who are experiencing social, emotional and behavioural difficulties. The charity aims to meet its objective by the operation of

a secure unit with a view to effecting the mental, physical and moral welfare of the young people within the school and, as far as possible, to encourage them to take their place as responsible citizens of the community.

The charity further aims to promote the provision of additional childcare and educational facilities to disseminate experiences, information and treatments.

The school appreciates that the definition of abuse is wide ranging and can manifest itself in many forms. St Mary's Kenmure acknowledges that the abuse of children took place within the school. It is accepted that inappropriate or excessive use of restraint is abuse and the Inquiry has also heard evidence of physical, emotional and sexual abuse. St Mary's Kenmure apologises for all instances of such abuse that took place within the school, whenever they took place.

St Mary's Kenmure regrets that the health and well-being of children were harmed by controlled drugs being brought into the school by staff members and the removal of home leave as a form of punishment was, and remains, unacceptable. St Mary's Kenmure apologises for all instances in which it was used as such.

The Inquiry, of course, did not only hear evidence about the school's past. The present day was also

a focus. Following a Care Inspectorate inspection in September and October of last year, a number of damning findings were made. These included environmental safety, child protection and safeguarding being consistently compromised, meaning children were not being cared for safely. Children being subject to or witnessing high levels of physical restraint, which was often disproportionate to the level of risk presented.

LADY SMITH: Yes, you make an important point there that came out in the evidence, that it is not just being the person subjected to restraint that can be distressing, but seeing a restraint can distress other young people.

MR HENRY: Indeed, my Lady.

There was also an absence of effective recording and reporting around risk management, leading to a high risk of very poor outcomes, and what was described as dangerously low staffing levels.

An improvement notice was served on the school and emergency conditions imposed. The improvement notice required the school to:

(1) ensure that the environment provides maximum security of safe care to children and staff.

(2) ensure that an appropriate number of staff were on duty, ensuring the right balance of qualification and experience.

(3) ensure that effective safeguarding procedures relating to child and adult protection are in place and being followed.

(4) ensure that the admissions procedure is effective to keep young people safe.

(5) ensure that there is effective recording, oversight and analysis of incidents, including restrictive practices.

(6) to protect the safety of those who use the service.

The school was ordered to stop taking new admissions and a limit was placed on the number of children who could be placed within the school.

As the Inquiry has been advised, St Mary's Kenmure accepted all of the Care Inspectorate's findings. The school has been cooperating with the Care Inspectorate to address the serious issues identified.

When submissions were made on St Mary's behalf at the close of Chapter 11 of this phase in late December last year, the Inquiry was advised that the Care Inspectorate had been in the school that very week.

Following that visit by the Care Inspectorate, St Mary's was notified that the requirements relating to child protection, staffing and the security of the environment had been met, with other requirements on

track to be met.

The Care Inspectorate have ended their regular site visits to St Mary's Kenmure. The current schedule is for visits every six weeks. St Mary's roll is currently capped at a maximum of 12 children and this is to be reviewed again on or after 10 March 2025.

As I indicated, St Mary's Kenmure accepts all of the Care Inspectorate's findings and -- as hopefully can be seen from the update provided -- is working with the Inspectorate. As the Inquiry has identified, the more powerful the lens that can be used to examine St Mary's Kenmure, the better. St Mary's Kenmure has made improvements to its governance of practice within the school. The board receives regular updates on the progress with the requirements imposed by the Care Inspectorate, and also receive regular updates on child protection issues and restraint activity within the school, which is reflective of improved governance at service level.

St Mary's Kenmure regrets and apologises for the deterioration within the school. It is unacceptable that matters reached the stage that they had. St Mary's Kenmure apologises to the children who have been impacted by these events.

St Mary's Kenmure understands that the restrictions

placed on it places the secure care sector in Scotland at greater risk of being unable to provide a service that meets demand. The measures imposed by the Care Inspectorate have had a significant impact on St Mary's finances, this has come at a time when the formerly new secure unit is reaching the end of its intended lifespan.

The Inquiry has heard evidence in relation to St Mary's Kenmure from decades past up to the present day. St Mary's Kenmure did not seek to question the evidence of the survivors. It again apologises for all instances of abuse that occurred within the school. It accepts that harm was caused to children as a result of their time in residential accommodation. It acknowledges the suffering of survivors and their bravery in coming forward. It apologises for the failings which contributed to their pain and suffering and St Mary's Kenmure remains grateful for the opportunity to participate in the Inquiry's proceedings.

LADY SMITH: Yes. I am sure you don't mean to give that impression, but we should probably confirm, Mr Henry, where in paragraph 15 you are talking about the risk to the whole sector if a school such as St Mary's has a cap put on its numbers and numbers are restricted, then you talk about the significant impact on St Mary's finances,

which I think you are saying compounds the problem, but can I just have you spell out, you are not saying that the Care Inspectorate should hold back from criticising if its requirements are going to cost money to the organisation?

MR HENRY: Absolutely not, my Lady, and that certainly wasn't my intention. I apologise if that's the impression that it caused.

LADY SMITH: There's no need to apologise, I think in fairness to St Mary's I need to have that spelt out and sometimes a voluntary organisation may just have to take it on the chin if they are not up to standard, and not only are they going to have less that they are allowed to do, but that means their income will drop.

MR HENRY: Indeed, my Lady.

LADY SMITH: Thank you.

Now.

MR HENRY: That leaves me finally with the Good Shepherd Sisters.

Closing submissions by Mr Henry on behalf of the Good Shepherd Sisters

MR HENRY: My Lady, I again appear on behalf of the Congregation of Our Lady of Charity of the Good Shepherd, who for brevity's sake I will refer to as the Good Shepherd Sisters.

LADY SMITH: Yes.

MR HENRY: They were formed following the amalgamation of the Order of Our Lady of Charity and the Order of Our Lady of Charity of the Good Shepherd, which was formed by Sister Mary Euphrasia Pelletier in 1835, in France.

The two congregations shared a common origin, that of the Order of Our Lady of Charity, which was also formed in France in 1641. The Order had the stated goal of caring for girls and women.

In 1825, Sister Mary Euphrasia was appointed Superior of the Community of the Order in Tours, France.

In 1829, she was asked by the Bishop of Angers to set up a home for girls and women there. That home opened in 1829 and was called the Good Shepherd, in memory of another house with a similar ministry which had existed in the previous century.

The Generalate was approved in 1935, and with this approval, the church established a congregation distinct from the Order of Our Lady of Charity. The Order have cared for children since their beginning in France.

The Good Shepherd Sisters is an international apostolic religious institute of pontifical right. It is not subject to the diocesan hierarchy for its internal workings, but is committed to working with the authority of the hierarchy according to its norms. The

Order has its own Superior General and a General Chapter that meets every six years. The Provincial Superior in the United Kingdom is Sister Anne-Josephine Carr.

The Good Shepherd Sisters' interest in this phase of the Inquiry's work relates to Dalbeth School and St Euphrasia's Training Centre in Bishopton, Renfrewshire.

At the outset of these submissions, the Good Shepherd Sisters wish to make clear that they apologise to all those who suffered abuse at Dalbeth School and St Euphrasia's. The Sisters did not seek to question, challenge or minimise the evidence of survivors who gave evidence before the Inquiry. It is accepted that there will be others who have suffered who have not yet come forward. The Good Shepherd Sisters have the greatest sympathy for all survivors who have suffered and for all those who were let down by the care system.

As was outlined in the closing submissions in Chapter 11, my Lady, the Good Shepherd Sisters moved to Bishopton after having left Dalbeth, Glasgow, where Dalbeth Girls' School operated as an approved school.

St Euphrasia's Training Centre was opened in the summer of 1948, with Dalbeth Girls' School opening in 1953.

The St Euphrasia's Centre was formed in 1971

following a merger of these two institutions. St Euphrasia's Centre was an independent residential establishment governed by a voluntary Board of Managers, the responsible parent body being the Sisters of the Good Shepherd.

By the 1980s, the Sisters had appreciated that they were not going to be able to staff St Euphrasia's Centre indefinitely. Following discussions with the Catholic Hierarchy in Scotland, it was decided that the centre would be handed to the Hierarchy.

In 1981, the Hierarchy took on responsibility for the centre, which continued to be governed by a voluntary Board of Managers.

In 1995, the property was sold to the Cora Foundation, and on 1 April 1996, the last of the Sisters left Bishopton.

My Lady, the Sisters acknowledge that the definition of abuse is wide ranging and manifests itself in many forms. It is accepted that abuse took place in Dalbeth, St Euphrasia's and the St Euphrasia's Centre. Survivors have given evidence of physical, emotional and sexual abuse. There is evidence before the Inquiry of the use of a punishment or detention room and of children being punished for bedwetting. The Inquiry has also heard evidence from survivors of the use of corporal

punishment.

It was a fundamental tenet of the Good Shepherd Sisters that they were never to strike children. This followed an instruction from Sister Mary Euphrasia that children were not to be struck nor harsh measures used. Sister Mary Euphrasia directed that the order was to stand forever and always as though it were inscribed and printed everywhere. The order applied regardless of whether corporal punishment was permitted by the law or statutory regulations which applied within any jurisdiction within which the Sisters were operating.

As your Ladyship previously identified, perhaps the order ought to have been inscribed and printed everywhere. While it may have been considered enlightened for its time when corporal punishment was still permitted in Scotland, the Sisters accept that people do not always adhere to the high standards expected of them and a policy can only be as effective as those administering it.

The Good Shepherd Sisters accept that despite the clear and direct instruction that children were not to be struck, corporal punishment was used and the Sisters apologise for this.

The Inquiry has also heard evidence of children, including children as young as 11, being put to work in

a laundry. That was an extensive commercial operation, children were put to work on 12-hour shifts.

LADY SMITH: In silence.

MR HENRY: In silence, my Lady.

The dangerous and unpaid work was, of course, not suitable for children.

My Lady, the Good Shepherd Sisters have not been able to identify whose decision it was that there should be such a commercial operation carrying out laundry work in Bishopton, but laundries were a long-established part of the Good Shepherd Sisters' work. It is accepted that children should not have been exposed to the dangers involved in working in a commercial laundry. It was, of course, inappropriate and unacceptable.

The Inquiry also heard evidence of children being used to clean the buildings in Bishopton. This included the use of bumpers. While children should not have been used to clean buildings at all, the use of these heavy devices was particularly inappropriate, and the Good Shepherd Sisters apologise to all those who were made to work in this way.

The combination of laundry and cleaning work meant that, as was outlined in evidence, some children did not receive any education. Others received inadequate education. The Good Shepherd Sisters apologise for

this.

The Good Shepherd Sisters are, however, my Lady, no longer involved with the provision of residential accommodation for children in Scotland. There are only a small number of Sisters remaining in Scotland. The Sisters accept that harm was caused to children who are now adults as a result of their time spent in residential accommodation.

The Sisters acknowledge the suffering, trauma and pain that the survivors have experienced and the bravery in coming forward. They apologise to all those who have suffered harm as a result of their time spent in the care of the Sisters.

The Sisters deeply regret the harm that was suffered by young women and children who were placed within their care in Bishopton. The Good Shepherd Sisters welcome this Inquiry and appreciate it is important for all voices to be heard. The Sisters regret that survivors have painful memories of their time spent in care. They are grateful to the Inquiry for the opportunity to participate in its work, and remain committed to assisting the Inquiry in any way that they can.

LADY SMITH: Thank you very much, Mr Henry.

I would now like to turn to Renfrewshire Council and Mr Young, I think you are here for Renfrewshire, is that

right?

Closing submissions by Mr Young on behalf of Renfrewshire Council

MR YOUNG: Yes, my Lady, good afternoon.

I am here representing Renfrewshire Council. Your Ladyship has the written submission, which is extremely brief, on behalf of the council. I don't really intend to elaborate much on what is there.

That is largely because Renfrewshire's interest in this phase of the Inquiry's business was in relation to Newfield Assessment Centre, subsequently known as Rowanlea, which was dealt with in Chapter 10, only a matter of a few months ago.

LADY SMITH: Yes.

MR YOUNG: A lengthy, or more lengthy, submission was given by the council after that, which sets out, really, any findings or any themes that the council would suggest your Ladyship may take from that particular part of the business.

All I suppose I would wish to highlight from that submission at this point, my Lady, would be just to reiterate that Renfrewshire Council does not seek to dispute any of the accounts or evidence given out by the applicants in relation to their experiences at Newfield. It has accepted and does accept that abuse happened at

Newfield. It also accepts that there were failings on Renfrewshire Council's part in relation to retention of records regarding Newfield and also some of the record keeping that took place from those records that we do have.

It apologises again for the abuse that happened on the part of its predecessor organisation and for the failings that are attributable to Renfrewshire Council itself.

I would simply wish to add, my Lady, on behalf of the council, that it wants to take this opportunity to express its wider gratitude to applicants that were heard as part of all of the other chapters which will feed into your Ladyship's findings as part of this phase, and it looks forward to seeing those findings and reflecting on them in due course.

LADY SMITH: Yes.

One thing I would be interested in your response to, Mr Young, is the whole notion of an assessment centre. It appears to emerge from the evidence that there was a problem across the board with all the assessment centres, that they weren't actually assessing children at all and in some cases children remained there for far too long, on the basis, it seemed, that nobody was able to think of what to do with them next.

MR YOUNG: Yes.
LADY SMITH: Is that accepted?
MR YOUNG: Yes, I think that would be accepted by Renfrewshire. I think this council's feeling on that front might be put short as the idea of assessment centres, while on the face of it, perhaps, maybe one might say instinctively attractive, it really was a flawed idea, but it was also a flawed idea that really wasn't put into practice in any way, and the culture of the previous detention centres really carried across, so that what little assessment maybe took place was against a backdrop of, really, a more disciplinarian environment than would be in any way suitable for a proper assessment of a child's needs.
LADY SMITH: Mm-hm.
Of course, I haven't heard directly from any sheriff or any Children's Panel member at the time, but it seems I may be able to infer that they genuinely thought that they were sending children to be assessed, and for it to be responsibly and professionally worked out what was the best next step for the child.
MR YOUNG: I believe they did, my Lady. I don't think it would be correct to say that there was absolutely no assessment done --
LADY SMITH: No.

MR YOUNG: -- but what assessment was done, as I say, was on a flawed basis.

LADY SMITH: Yes.

MR YOUNG: Mr Trainer, the Renfrewshire Council's Chief Social Work Officer, when he gave his evidence, I recall, said that really the idea that you take a child out of their environment to assess what they need in order to work within that environment is really fundamentally flawed. When you think about it in those terms perhaps, it is obvious that it is flawed.

LADY SMITH: Yes. Thank you very much for that.

MR YOUNG: Thank you, my Lady.

LADY SMITH: Thank you, Mr Young.

Then lastly for today, welcome Mr Pugh, you are here for Glasgow City Council, I think, yes?

Closing submissions by Mr Pugh on behalf of Glasgow City Council.

MR PUGH: Yes, thank you, my Lady.

My Lady, it is not the first time that this Inquiry has heard about the benefit of sunlight as the best form of disinfectant and this phase of the Inquiry's important work has shown again the truth of that statement.

Your Ladyship has the council's written submissions, and, as I have done in the past, I don't intend simply

to read out all of those. Instead I am only going to go through some of the more important, as I see it, paragraphs and I will direct your Ladyship by paragraph number.

LADY SMITH: Thank you.

MR PUGH: Starting with paragraph 3, my Lady, at the commencement of this phase, and following the conclusion of each of the chapters, the council has acknowledged that abuse took place within each of the institutions it ran, or were ran by its predecessors, and offered an apology to the children and young people who experienced abuse.

It is only proper, my Lady, that following the conclusion of this phase of the evidence, and during a time of reflection for the council, that apology is once again reiterated to the children and young people who were abused within residential care establishments run by Glasgow City Council and its predecessors. The council is deeply sorry.

Moving on to paragraph 8, my Lady, this phase of the Inquiry has again been challenging for the council. The evidence heard in relation to residential care services from the 1960s through to the 2000s has testified to abuse of the most serious kind, and over an extended timeframe.

There is no doubt that such abuse was systemic. In particular, the institutions of Larchgrove and Kerelaw were subject to independent review and concerns were raised but not acted upon.

As such, a culture was created whereby abuse was accepted, and commonplace. Indeed, my Lady, the mere number of abusers that were discovered at Kerelaw in particular would tend to support that the abuse was systemic at that school.

Of the institutions investigated, the council has by far the greatest knowledge in relation to Kerelaw. A number of members of the senior leadership team that have been involved in this Inquiry have personal recollections of the closure of that institution, and the investigations and learning that followed.

The level of abuse at Kerelaw -- I distinctly recall your Ladyship raising this point with me when we closed the Kerelaw phase -- in terms of both its quantity and severity is frankly astonishing. It will be of significant concern to the Inquiry, as it is to the council, that it was allowed to continue for so long and at such a level. The criminal proceedings to date demonstrate the scale of the problem, and must be one of the worst instances of such conduct to have come before this Inquiry.

The closure of Kerelaw School is considered by the council to have been a significant turning point in its progression and development of modern residential care services.

Other institutions where applicant evidence was led within this chapter; Larchgrove, Beechwood and Cardross Park, are less familiar to the current management of the council. In relation to Larchgrove, it wasn't until this Inquiry was underway that the Bennett and Righton report became known to the current management of the council, albeit that there is no dispute as to its contents and that it was available to the council at the point that it was commissioned.

LADY SMITH: Yes.

MR PUGH: The council accepts that there are echoes of the situation at Larchgrove that were magnified and exacerbated by the time one looks at Kerelaw, indicating that the lessons available were not learned.

Beechwood and Cardross Park were even less familiar, having been largely, or wholly, governed by predecessor councils and inherited by Glasgow following local government restructuring. The council has tried to assist as best it can with the Inquiry's investigations in relation to those institutions, despite limited physical records.

Applicant evidence of experience at those institutions presented a mixed picture. Where there was evidence of positive experiences within residential care, in Beechwood in particular, there was also evidence of abuse, and the nature of that abuse was varied.

Practices which were commonplace in wider society at the time can now be recognised as wholly inappropriate, particularly in relation to methods utilised in order to attempt to manage children and young people exhibiting challenging behaviours. As we explain below, my Lady, the council's approach to nurturing children and young people in its care has developed, thankfully, significantly.

My Lady, the council does not seek to excuse or to minimise the criminal conduct that occurred at Kerelaw and these other institutions, but within these submissions we will now seek to highlight that the current residential care provision is unrecognisable in comparison.

With that, my Lady, if I can turn then to paragraph 15 in the key themes, these are the key themes that we have identified at the close of each of these phases, and where we have indicated that we would provide further information.

LADY SMITH: Yes.

MR PUGH: Starting with restraint, my Lady. The Inquiry has heard significant applicant evidence of restraint practices which were both unnecessary and abusive. The evidence from Kerelaw in particular demonstrates that inappropriate restraint was commonplace.

Training in how to intervene physically in potentially harmful situations was not an initial requirement for staff working at either Larchgrove or Kerelaw. I think the same can probably be said of Cardross Park as well, although we weren't able to find any specific evidence in relation to that. It may be that the Inquiry has it and we have just missed it, my Lady, but I think the same can certainly be accepted in relation to Cardross Park.

Your Ladyship might recall at least one member of staff from Kerelaw describing receiving some training in pain techniques as an aspect of restraint.

LADY SMITH: Yes.

MR PUGH: There was perhaps a sense, my Lady, that in the early days restraint was no more than a shadow for physical chastisement or other abuse, rather than what we would now understand as being restraint.

LADY SMITH: Yes.

MR PUGH: Not that that minimises it in any way.

Many witnesses described Therapeutic Crisis Intervention (TCI) training, the programme that was introduced by the council in the 1990s. That was a feature particularly in relation to both Kerelaw and Cardross Park.

The model appeared to endorse de-escalation prior to any physical intervention, but the Inquiry heard clear evidence from both applicants and former staff members that TCI was not uniformly adhered to. Indeed -- and this is important, my Lady -- there was a sense from the evidence that staff sometimes appeared to view the training as an increased warrant to restrain, effectively bypassing the de-escalation stage. Training was sporadic and inconsistent and abusers utilised opportunities to restrain in order, it seemed, to perpetrate physical abuse on residents.

The culture of residential institutions was such that children exhibiting challenging behaviours were simply restrained and labelled as problematic, rather than any attempt being made to understand their unique and complex needs.

It is the council's position and, indeed, that of Ms Millar in her evidence that there will always be a requirement for local authorities to have procedures in place which are utilised if a child or young person

places themselves, or others, at physical risk of harm.

The council has provided the Inquiry with documents which detail and explain the current model of safe holding, which is termed 'promoting positive behaviour'. The framework was introduced in 2016 and training is delivered to social care staff in children's houses, older people in residential services, learning disability services and homelessness services. 400 to 450 staff are trained annually, with the training requiring both e-learning and attendance in a classroom setting.

The training is refreshed and takes place alongside training in other topics, such as nurturing, adverse experiences, emotional containment, and the impact of trauma, the ethos being to promote a holistic approach.

The council believes strongly that it is not simply the physical safe hold techniques which require to be carefully considered and managed, rather the focus of training and education should be on the social care staff's entire approach to caring for vulnerable individuals.

Since the introduction of the nurture framework in 2021, the council's experience in recent years is that incidents where physical intervention is required to ensure safety have decreased. The council is currently

developing a system to improve how data in relation to physical restraint is gathered and reported on, but as an example of current statistics, in 2023 there were 255 recorded incidents of safe holds, while in 2024 this reduced to 152. Of course, it is accepted, my Lady, that that's a limited sample size.

LADY SMITH: Yes.

MR PUGH: It is, of course, accepted that it reflects recorded incidents only, but the council submits that it does reflect a significant cultural change from the terms of the applicant evidence that was heard in this phase, where it is clear that restraints were commonplace and reported by many essentially to be a daily occurrence.

LADY SMITH: Your reference to data reminds me of the stress that Amanda Hatton from City of Edinburgh Council put on the importance in the modern world, because we can gather it, and we can make it readily accessible, of data, particularly in this field. I don't know if your Council has followed that, but she explained how she feels in a much stronger position if she has access to all relevant data in relation to the work that they are doing with children. This is the sort of thing you can track, if you keep the data and you make it readily accessible.

MR PUGH: Well, indeed, and as I will come on to say in relation to allying this type of training to a proper complaints procedure that allows these things to be considered.

LADY SMITH: Indeed.

MR PUGH: I haven't specifically discussed with the council Ms Hatton's evidence, but there have been a constant watch on the Inquiry by senior members of the council staff, so I will certainly make sure that is passed on, my Lady.

LADY SMITH: Your council are probably aware she is a relatively recent arrival in Edinburgh, 2021, having come from south of the border, and came in, and has implemented some new ideas on organisation and management, which, as I say, you may find of interest.

MR PUGH: I will certainly make sure that that has been observed, my Lady.

LADY SMITH: Thank you.

MR PUGH: The current Promoting Positive Behaviour model is under continuous review by the council. In January 2022 a review of the physical intervention techniques taught by the Promoting Positive Behaviour training was conducted by experts at Robert Gordon University, and we have provided some of that at appendix 1 to this submission.

Changes are regularly made to the terms of the training to reflect the council's developing trauma-informed approach, and we have provided evidence of that at appendices 2 and 4.

In May 2024, a full-scale review of the Promoting Positive Behaviour programme was conducted by the Clyde Valley Promoting Positive Behaviour Strategic Governance Group. Changes to the programme were made to reflect the experiences of stakeholder councils and that has been provided at appendix 3, and the Inquiry can consider those at its leisure.

The council is committed to conducting reviews of Promoting Positive Behaviour and the terms of its Promoting Positive Behaviour training in order to ensure that practice is developed in line with the experiences of practitioners.

Moving then away from specifically restraint and on to training and policies more generally. The Inquiry heard evidence that there were no formal qualification requirements for staff employed in residential care services until the SSSC introduced the register for social care staff in 2003. There was then a phased introduction of mandatory qualification requirements throughout the following years.

The residential institutions covered within this

phase had no formal qualification requirements and staff generally commenced employment entirely untrained. On-the-job training was limited, inconsistent, and informal. Staff members largely spoke of limited formal regulation, or independent audit, and starkly spoke of no formal staff code of conduct. Recruitment practices at Kerelaw School were in particular the subject of justified criticism in the Frizzell report.

There, staff were largely drawn from one small community and mostly knew each other, and that's a point I will return to, my Lady.

LADY SMITH: Yes.

MR PUGH: The historically unregulated landscape of child services is unrecognisable when compared to the current position. Residential care staff are now required, as a minimum, to undertake an SVQ 3 in care for children and young people.

Following a question asked of Ms Millar in her evidence during Chapter 10, the council provided statistics in relation to the qualification levels of residential care staff following the introduction of the registration requirements in 2005. At present, each residential care worker is required to undertake a qualification for registration after six months in post, unless they come with an appropriate qualification

that can be evidenced.

Staff training is rigorous and regular. All staff are registered with the SSSC and required to complete at least 30 hours of training per year. A mandatory training programme for residential care exceeds this, providing a range of training, including a four-day nurture training, a three-and-a-half-day Promoting Positive Behaviour programme, child protection, adult support and protection, fire safety, suicide awareness and intervention, as well as training and supporting individuals who are neurodivergent, and that teams have five hours of protected time each week which focuses on the integration of learning through coaching from a range of partners, including speech and language, and educational psychology.

My Lady, I appreciate that many of those are beyond the scope of this Inquiry, but the training package itself seemed to us to be of interest --

LADY SMITH: Yes, thank you.

MR PUGH: -- to the Inquiry, to understand more than just what, I suppose, is directly relevant.

The service has developed a Nurture Through Leadership programme that provides ongoing training, learning and coaching to leadership teams to support the implementation and integration of nurture, being

supported by colleagues in education, including a team of educational psychologists.

The service has engaged with night shift colleagues to understand and respond to their specific learning needs. The outcome of this consultation has been developed through the Nurture At Nights programme, which provides on-site training and coaching, provided by senior practitioners, with the support of a senior learning and development officer. This work has been undertaken to support best practice in Glasgow and ensure that children and young people receive the best possible care when living in a residential house.

LADY SMITH: What does that title 'Nurture At Nights', denote, Mr Pugh?

MR PUGH: It denotes the specific, as I understand it -- the start of it is a bit I skipped over, that appears earlier in the submissions.

LADY SMITH: Yes, I thought I read it somewhere.

MR PUGH: Yes, at paragraph 7 we talk about the development of following The Promise of the nurture framework.

LADY SMITH: Yes, yes.

MR PUGH: I don't know specifically, my Lady, but I suspect that the Nurture At Nights element of that recognises the particular place of night staff within these residential houses.

LADY SMITH: Residential care --

MR PUGH: Indeed.

LADY SMITH: -- and the differences in giving night time care as compared to day time.

MR PUGH: Indeed, night time care, and also if your Ladyship recalls the evidence that Ms Millar gave of the current position in residential care was that there would be a reduced number of staff on at nights.

LADY SMITH: Yes, of course.

MR PUGH: I think that's a matter that your Ladyship explored with Ms Millar.

LADY SMITH: Yes.

MR PUGH: I am almost certain that it is in relation to that, my Lady, but I can, if it is needed, provide any further clarification.

LADY SMITH: That would make sense, thank you.

MR PUGH: Paragraph 25, the council has previously provided the current code of conduct for social care staff. It is important that care staff know what is expected of them and what support they are entitled to expect from the council in return.

It is recognised, my Lady -- this again is important -- that work in children's residential services, whilst enjoyable and immensely rewarding, can be challenging and stressful. It is these challenging

and stressful moments where training policies and organisational ethos become acutely important. The evidence heard by the Inquiry has demonstrated that at times there was institutional reluctance to develop practice surrounding childcare, and specifically a reluctance to learn lessons from previous investigations. Again, we have highlighted the lack of a response to the Bennett and Righton report being the most obvious of those.

LADY SMITH: Yes.

MR PUGH: The council's approach, which has been its approach now for a number of years, seeks to place the nurture of children at the centre of staff training and policy.

In relation to complaint handling, the evidence heard by the Inquiry demonstrated a clear lack of sufficient complaints procedures in each of the institutions explored. Some applicants described lip service being paid to complaints yet no formal action being taken. Staff members who were the subject of serious complaints continued to work, whilst lengthy investigations were undertaken, often with limited or no resolution.

The council acknowledges that high-quality training procedures are inadequate without a robust and

independent complaints procedure to ensure that issues are quickly and appropriately identified and dealt with. To put it acutely, my Lady, they go hand in hand.

LADY SMITH: Yes, of course.

MR PUGH: Without those procedures, children and young people would continue to be placed at risk of harm. Abusers may continue to perpetrate serious abuse for many years, a stark example of that being the shocking and sustained conduct of Matt George and John Muldoon at Kerelaw.

However, even when complaints procedures exist, the culture within the particular care provision can impact upon whether residents or other staff members feel willing and able to report incidents of concern. That was particularly the case at Kerelaw where, due to the recruitment practices I have already alluded to, staff members largely came from the same local community and were known to each other in a personal capacity.

It is essential, my Lady, that a culture of openness and transparency is cultivated by local authorities so that the complaints process is trusted by complainers and those who are subject to complaints.

At paragraph 28, we have highlighted some of the other documentation that's been provided as appendices to this.

I should say, my Lady, your Ladyship may have noticed appendix 6 was not a document created by the council, it is a document created by the Scottish Public Services Ombudsman, that's simply a typographical error, it is relied upon by the council in preparing its guidance.

LADY SMITH: Thank you.

MR PUGH: Provision of education is the penultimate topic, and from paragraph 29, while much of the applicant evidence focused on particular incidents of physical and emotional abuse, the wider context of the applicants' experiences within residential services is important in understanding how being in local authority care impacted their long-term well-being, education, or more appropriately, my Lady, the lack thereof, was an important factor in many of the applicants' experiences.

Residents entered assessment centres, and I have listened with care to the discussion your Ladyship has just had with Mr Young around assessment centres --

LADY SMITH: Yes.

MR PUGH: -- but for the council that was Larchgrove, Beechwood and Cardross Park, with the expectation that they would only be staying for a short period. Education was not prioritised and often was entirely

lacking, despite residents often staying for a number of months and in some instances years.

LADY SMITH: Yes.

MR PUGH: I suspect of particular concern to your Ladyship, in many respects, the all-female nature of Beechwood meant that education amounted to learning homemaking skills and crafts.

LADY SMITH: There is nothing wrong with teaching homemaking skills and crafts to all children.

MR PUGH: Of course, my Lady.

LADY SMITH: It is just it is not a substitute for the other aspects of educating a child.

MR PUGH: Of course it is not. Of course it is not.

Kerelaw was notionally both a residential home and a school, but the evidence from applicants was the education provision was at the very least, at the very least, not suitable to the needs of individual residents.

Throughout the tenure of the relevant establishments, children of school age in Scotland were entitled to education, it is inexcusable that the establishments failed to meet these duties in that regard.

Current local authority structure means that within Glasgow City Council, social work and education services

work closely together to ensure that all children and young people in residential care have an allocated school placement and provide outreach support where that is required.

Each house, that's a residential house, my Lady, has an allocated educational link worker who is responsible for coordinating the education plans for children and young people alongside the children's house, the school and the young person. A range of partners support education to offer diverse and individualised care plans that reflect the strengths and needs of the young people, this includes both school-based provision, as well as off-site teaching and learning opportunities.

Undeniably, securing school attendance for vulnerable children and young people has become an increasing challenge following the pandemic, but it is an issue felt throughout the school population as a whole.

Horseplay was the final topic that we identified in a number of these chapters that the council participated in. At times what might be termed 'horseplay' took the form of organised fighting, and that was an issue that was prevalent in the earlier evidence, particularly pertaining to Larchgrove and Kerelaw. The conduct described by applicants captures, what we would suggest,

a macho culture at those establishments and undoubtedly, my Lady, that culture allowed abuse to occur undetected.

LADY SMITH: Yes.

MR PUGH: The structure of residential care is now wholly different. Residents are cared for in smaller houses with fewer children within the same placement. Although the council seeks to cultivate close bonds between staff and residents, qualification and training requirements make clear that boundaries to that relationship exist and cannot be crossed. In changing the model of residential care following the closure of Kerelaw, the council submits that although incidents between residents occur on an individual basis, the macho culture previously prevalent is now eradicated.

The council have previously provided statistics to the Inquiry in relation to the health and safety incidents within children's residential services between 2021 and 2023. Those statistics show a limited number of physical incidents within services in recent years. The majority of reported incidents are attributable to smoking, slips, trips, falls and damage to property. In 2023 there were 22 recorded incidents of knives or offensive weapons within residential care, with one recorded incident of horseplay.

Then just trying to summarise that in relation to

the present position, Susanne Millar, throughout her evidence within this chapter, testified that the nature and structure of the current residential care provision within Glasgow City Council is entirely different from the establishments covered within this Inquiry phase.

The council no longer runs secure accommodation, nor does it run residential schools. Instead, children and young people are cared for within 19 children's houses located within the city boundary. The model is intended to feel homely, the houses being intentionally indistinguishable from the surrounding locality, in direct contrast to the institutions of old.

Each house has between six and eight children residing within it and placements are tailored to the needs of each individual young person. Childcare plans are carefully created with direct input from children and young people themselves. Residential care staff are required to have knowledge and understanding of the care plan of each child within the service. Within this model it is hoped the institutional feel of previous residential care services has been lost in favour of a family-based environment.

Ms Millar described a personal view that residential care services will always require to be provided by the council in some form, given the particular needs of some

children and young people in the council's care. The current model is considered by the council to be the best way to meet that need whilst ensuring the welfare of residents is protected.

Thank you, my Lady.

LADY SMITH: Thank you very much, Mr Pugh.

Well, that completes the submissions that we have planned for today, so I will stop now.

We will be sitting again tomorrow afternoon, not tomorrow morning. The details of who we should be hearing from are on the website, but just to remind anybody who wants to know now: the Church of Scotland Social Care Council, otherwise known as CrossReach; the Archdiocese of St Andrews and Edinburgh; Loaningdale School Company Limited; Dr Guthrie's School; Rossie Young People's Trust; Aberdeen City Council; Inverclyde Council; and Kibble Education and Care Centre are all organisations who will have the opportunity to present closing submissions tomorrow, which, as I say, will start at 2 o'clock, and I think we will manage to finish those tomorrow afternoon, they should fit in the time available.

Mr MacAulay, is there anything else you need to address me on at the moment?

MR MACAULAY: I don't think so, my Lady.

LADY SMITH: Very well. I will rise now until tomorrow afternoon at 2 o'clock.

(2.56 pm)

(The Inquiry adjourned until 2.00 pm on Thursday, 13 February 2025)

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