Scottish Child Abuse Inquiry

Witness Statement of

John DALRYMPLE

Support person present: No.

1. My name is John Darge Dalrymple. My date of birth is [redacted] 1953. My contact details are known to the Inquiry.

Qualifications/Background

2. I completed a Degree in Literature in 1974 before becoming a social work trainee later that year with the Glasgow Corporation as it was then. Over the course of 1975, I completed a Diploma in social work at Glasgow University and later, in 1976, the Postgraduate Certificate of Qualification in Social Work at Edinburgh University. After studying I had to return to working in Glasgow because they had funded my training. I stayed in Glasgow for a year before going to work in Galashiels as a social worker in the area team there.

3. I had some involvement during my area team days in Galashiels with children living in a children's home, The Priory, in Selkirk. I think the specialist health services for children in the Scottish Borders at that time were provided largely from Edinburgh. If they were getting any therapeutic input, the area team had the responsibility for them and I would go in to visit them and go on trips with them. If there was any sort of clinical or NHS input, it would come from the Sick Kids in Edinburgh.

4. The Priory was my first introduction to, and understanding at an in-depth level, of what children went through and what they experienced. I worked in the Galashiels area

team until 1982 when I moved to the learning disabilities team based within Dingleton Hospital which was the psychiatric hospital.

5. Dingleton Hospital was famed in its day for having a therapeutic community approach which was advanced in the thinking of the day. The learning disability component of the hospital was quite small with only one ward of twelve people. The hospital was a base for us to go out to different parts of the Borders as a community team.

6. On alternate weeks we would either visit the institution for women at one end of Galashiels, Balnakeil House or the one for men, Brothers of Charity on the edge of Melrose. The routine was that they would highlight any individuals they had concerns about. Part of that role could involve introducing some of those people to, not in any systematic way, a possible opportunity to live in a more domestic setting. The community team was made up of social workers, nurses, a doctor, as well as a part time psychiatrist. I did engage with one or two people and accompany them on trips to possible new opportunities for them. Other members of the team would be engaged in more clinical roles, possibly prescribing medication or taking bloods for tests and that kind of thing. At that stage, I don't remember there being children in those institutions we were involved with.

7. I was there until 1988 when I left and was the first employee for a third sector organisation called Partnership Housing. It was an organisation involved in helping people to leave Ladysbridge Hospital in Banff and Woodlands Hospital in Aberdeen. I was on my own to begin with but eventually we recruited more staff.

8. When I was at Partnership Housing, part of the general thinking was that everyone needed their own home without exception. That was the ideology but you need the right type of support to do that. There is nobody that needs to be in an institution. Partnership Housing was an unusual organisation in its origins in that it had been created by the regional council of the day, Grampian, and they got together four local organisations who were already doing some of this work, one being Cornerstone. I think at the time they didn't want to give all of the work to Cornerstone so they created this group.

9. In order to provide housing, they had come up with a scheme whereby the council could buy houses and lease them to organisations and generate a capital receipt. The guy who chaired it at the beginning was the previous director of finance so he understood how it all worked. We had considerable spending power in that market because of that. The housing part is an important component in all of this.

10. I was at Partnership Housing until 1992 when I became the principal social worker for learning disabilities for the Strathclyde region. Within that role we worked with four different health boards and covered a huge area with half the population of Scotland being within Strathclyde Regional Council area. A lot of that time in those three years was spent joint planning with those health boards with regards to the future of the population who were in long stay hospitals at that point. There were about fourteen hospitals at that time across Scotland as a whole. In 1995 legislation then came in to get rid of Strathclyde Regional Council as a whole as part of local government reorganisation. People were being redeployed and from there I was sent to head up the closure programme at Lennox Castle from a social work point of view.

11. I had done some work of a similar nature when I was working at Partnership Housing, or Aspire as it is now, but it was a different matter to be heading up the project. At that point, when we started, it was pre devolution so for a hospital to close, you had to get the permission of the Secretary of State. Some of my colleagues met with Donald Dewar in 1996 and he agreed that the hospital should close and so we started to implement that. I worked on that project until I left in 1998 when the first half of that project was complete.

12. On leaving Lennox Castle, along with a colleague, I started up an organisation, Support for Ordinary Living. That was a bit like going back to Partnership Housing. We were based in Lanarkshire and the target hospitals were Birkwood Hospital in Lesmahagow and Kirklands Hospital in Bothwell. We still didn't have a formal hospital closure programme in Scotland at that point. That came in 2000 after the Scottish Parliament had been formed and following the publication of the first learning disability policy paper which stated that all of these hospital should close by 2005. Birkwood

and Kirklands were caught up in that process. I was at Support for Ordinary living for ten years, leaving in 2008.

13. I then moved to an organisation called Neighbourhood Networks which was a very different kind of organisation which focused on fostering networks of peer support for those with learning disabilities who live largely independently in different parts of the country.

14. By 2017, a colleague and I decided to set up our own organisation called Radical Visions which I'm still involved with today. A lot of our work there is to do with training and consultancy with learning disability organisations but also advocacy for families and individuals who are stuck in the system and who are maybe not getting what they need to get out of it.

15. The medical model of disability dominated in the early days but the social model became more prevalent later on. The social work role in learning disability has parameters set out by the Social Work (Scotland) Act 1968. A lot of the work we did in the deinstitutionalisation field was in conjunction with, and at times in opposition to, the NHS because all of these hospitals had an NHS badge, although they weren't really hospitals. The patients weren't receiving treatment there, they were just contained. Our social work role was related to all aspects of health, welfare and wellbeing for children and adults that didn't cross over into healthcare. In relation specifically to learning disability, the social work role entails trying to organise community based support and services for individuals and families.

16. At times there have been two conflicting models; those of my generation were pushing hard for deinstitutionalisation, whereas others would be pushing for a much more traditional institutional model.

The Priory, Selkirk - 1978

Secondary Institutions - to be published later

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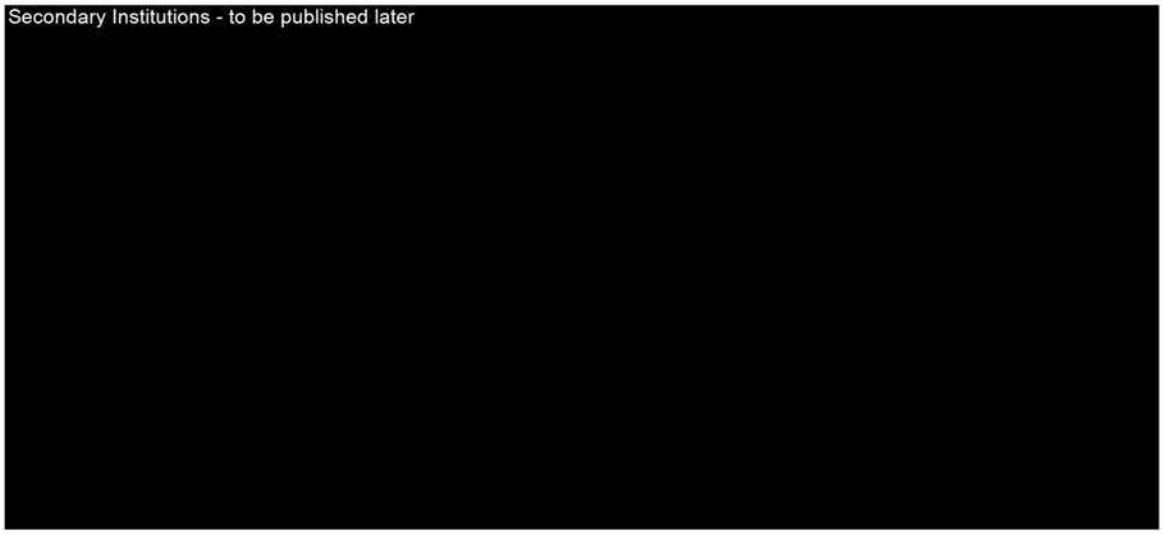
20. 

Lennox Castle Hospital, Lennoxtown – 1995 - 1998

Background

21. Lennox Castle opened in 1936 and during the war it served also as a maternity hospital. Prior to the Social Work (Scotland) Act coming into effect in 1968 it appeared to be common practice for disabled children to be admitted to institutions like Lennox Castle. Later, following the introduction of the Social Work (Scotland) Act, practice would have gradually changed and in terms of the children who were admitted, it was probably those who were seen as most disabled, maybe children who had a physical disability as well as an intellectual impairment for example. They maybe didn't have speech or verbal communication or there wasn't much nurture at home. They might have been seen as beyond the capability of a standard children's home to cope with or manage.

22. There's a very interesting brochure for the opening day at Lennox Castle and it has a statement by the medical officer in charge and he's basically saying how well we all do putting up with these people, referring to the type of people coming to live at Lennox Castle. There are earlier quotes that you can find that say that feeblemindedness is basically a medical problem. I think that's gone by the 1960s as you have the

beginnings of change around civil rights and the disability movement. You have the beginnings of the social model being articulated by people with physical disabilities and that influence begins spreading into practice. As ever, with a change of culture and practice, those older ways of thinking take time to fade away and are stubbornly enduring.

23. The cohort within Lennox Castle covers a wide spectrum of disability. You're going from people with a very mild learning disability, or none, through to the total other end of the spectrum and because the place was closing, not only did we want to, but we had to find solutions for people all across the spectrum.

First impressions

24. I had been to Lennox Castle once before, the year I went back to work in Glasgow. I think I was in the area team that covered Shettleston and Tollcross. There was somebody on my caseload at Tollcross and her brother or son was in Lennox Castle and she asked me to go up there and visit him. Back then, there were still Nissen hut type buildings on the campus and I remember that from that visit.

25. At the visit, I didn't really know what the hospital was for. It was outwith my experience at that stage, I didn't really understand it. It was like going to the poor house that my granny would've spoken about, that was my sense of it. It struck me as that kind of place but I had no responsibility for it and it was just a one off engagement.

26. It's a distant memory but by the time I got there in the 1990s a lot had been done in terms of modernisation, the buildings didn't look like that anymore but they still weren't great. People had very little privacy, they were in these long nightingale wards with a cabinet between the beds and there were no screens or privacy.

27. When I was then based there in the 1990s, the size of Lennox Castle struck me, it was significant and spread out over a large campus. I think there were about five hundred people living there when we got there. By the time I left, I think that number was down to about two hundred or so.

28. The wards were still largely split by gender. From the 1930s, 40s and 50s onwards there were strong efforts to keep the men and women apart. By the time I was based there, they were still being kept apart but not in the same rigid way, for example, a male ward could be next door to a female ward. I don't think there were any mixed wards.

29. In Lennox Castle there was just that sense of going in through the gates every morning and thinking that this was it for so many people. There was a man, a patient, who stood at the gate of the hospital every morning. He would leave his ward of a morning and he'd be there all day, just standing at the gate. It was symbolic for me, the nature of the place.

Culture

30. My impression of the culture was of it being very traditional, very authoritarian, quite macho in some ways. There were a lot of women employed but it was men in powerful positions. Some of that machismo was connected with sustaining the hospital, keeping it open. I wouldn't say it was facilitative or nurturing of people it was containment, low expectations of people and of what they could achieve. In response to our project, it was almost like the staff attitudes were, "Why would we bother to do this kind of thing? Why would we help people move to get a better life or have a home of their own?" It was as though they thought the people wouldn't appreciate it, or it's not important to them and they were quite happy at Lennox Castle.

31. Susan Brown was at the top of the hospital management but a lot of the ward managers were men. You do find that in the social work and nursing profession, it's mostly women who are employed but mostly men who rise to those positions and I think that changes the culture.

Recruitment to Lennox Castle and my role

32. When Strathclyde Regional Council was folding, they were redeploying people. I was the principal officer for learning disabilities so it was an obvious move for me. I was pleased to do it, it was something I would want to do but at the same time I wasn't particularly trained for it. Your training is very generic, you pick up things through the different roles you take up and gain knowledge. By that time I was pretty convinced of the need to separate housing from support which we tried to do as much as we could throughout the process. Meaning that if you were leaving healthcare, your landlord wasn't the same person as your support provider which was a fairly powerless position to be in, if you fall out with one, you lose the other and vice versa. I had a sense of a vision of where we wanted to get to but the detail of working it out was just really learning on the job, how to do that.

33. The Greater Glasgow Joint Learning Disability project was its official title and I was the project manager. I worked alongside a senior health board colleague and it was in the days of health boards and health trusts. The Trust ran the hospital and sat between us to some extent. We were located in an office in an administrative block within Lennox Castle, within a long corridor with social work at one end and the Trust at the other.

34. Since about 1990, possibly earlier, there had been social workers located there in an assessment role with a view to maybe helping some people move out, people who were judged to be more able, or who would be easy to help move or those who should never have been there in the first place. However, we were of the view that nobody should have been there in the first place. Those workers had gone kind of native, they had been located up there for years and they were kind of 'in with the bricks' with the health service so it took a bit to turn them around. They were the basis of an assessment team but there was money for the project so new people were brought into the assessment team who hadn't had that experience at Lennox Castle. That was tricky melding those two groups of people together and forming a shared ideology or attitude towards the work. Alongside that you had a commissioning team. These were social workers whose job it was to ultimately commission the social care that would

permit someone to leave the institution, to move from health care to social care. There was a team leader for each team, I was the person who managed those two people.

35. I don't recall there being any children at Lennox Castle by that point. You subsequently learned that children had lived there and that some of the women who we were working with had been taken there because they were pregnant and they had their child there. We also learned that some of those children were brought up in Lennox Castle and sometimes didn't have any sort of relationship with their mother who remained on the same site. That kind of abuse you learned about later, the destruction of, or not fostering, that relationship between mother and child.

36. Of those children at Lennox Castle, sometimes they had a learning disability which I think would have been the reason to keep the child there. To justify the mothers being brought in to give birth there, they would have to think that she had a mild learning disability. There were some people admitted to Lennox Castle who didn't have a learning disability but were seen to be feckless.

The decommissioning process

37. A member of the assessment team would be allocated to an individual person in a ward. The mechanism was that once it was clear that the hospital was closing, there was pressure to close one ward at a time. Immediately you're not dealing with what's best for the people, you're dealing with what's best for the finances and the stakeholder organisations, i.e. NHS and local authorities. That meant that some people got moved from one ward, to another ward and another as the support was not yet in place for them to move on.

38. We weren't ready, we didn't have the housing or support provider ready. We were approaching this from the view that we had to find solutions for everyone. Nonetheless the logistical problems lay there and we learned along the way that we were doing all of this assessment and social care planning but we needed housing. We then got housing colleagues dedicated to the team which was a real breakthrough.

39. The assessment worker would go and meet an individual and would come back with a report. At the beginning, that took far too long because as well as the financial pressures upon me, there was also a hurry up pressure, do it quicker, do it cheaper. But there were people in the middle of this and this was their one major life opportunity to get out of this place so that was hard.

40. We borrowed an approach from elsewhere called 'Essential Lifestyle Planning' which was a person centred, good value-based approach but it wasn't trying to do war and peace on every individual, although many of them would've warranted that. Once that report was ready, they would then bring that to their colleagues in the commissioning team and from there, it would be deciding what we could develop for that person. That would lead on to securing housing; if we got a sense of what the support requirements would be for that person then we could think about the housing that they would require.

41. Into the mix of all of that was an assumption, which we had to play along with for a fair bit of time, that most people would leave in groups. The housing we requested was shaped by having to accommodate groups of three, four or five people. We worked really hard to keep those numbers as low as possible. It was shared living or what's now called 'houses of multiple occupancy'. We called them group housing at the time. We knew that we were compromising on what we thought might be best. There were very few strong relationships amongst people, very few people who said to us that they would want to live with a specific individual. A man and a woman left together, they were in a relationship and we were able to facilitate that kind of thing. But where there were no obvious connections we had to go on the fact that they had lived on the same ward for a period of time or they both wanted to go back to a particular area of Glasgow.

42. Our commissioning team colleagues had to go to other hospitals like the Royal Scottish National at Larbert or Merchiston because there were people funded by the Greater Glasgow Health Board living in those places, so it wasn't just the population of Lennox Castle that they were dealing with. That was the main population we were interested in but any Greater Glasgow Health Board person across Scotland or even down South we had to track, so some of those people would come into the mix too.

43. We ultimately had a weekly meeting on a Tuesday and we could have twenty people round the table, the assessment team, commissioning team, housing people and we just worked through the case loads, action planning the way forward. All the while I'm being told to hurry up, do it cheaper and close that ward. It was quite stressful.

44. The residents were mostly up for leaving Lennox Castle, they knew what life was like there and were keen to move on. Families were a different story. There was a group called 'Friends of Lennox Castle', which was a group of parents and relative and these folk had been told over the years that admitting their family member to Lennox Castle was the best thing they could have done for their child at the time. I think a lot of misinformation as well as discriminatory information was fed to the families; being told not to have many expectations of their child. They've been told that this is for the best and that has been the arrangement for a number of years and then in come these whipper snappers suggesting that there may be something better outwith Lennox Castle. They were quite hostile to begin with. I remember one Saturday afternoon in particular, dealing with the Friends of Lennox Castle and it was as though you were being pounded with rotten fruit. You had to stick to your guns through all of that.

45. One of the things I learned, and I'd first learned it up in Aberdeen, was that if I was talking to a person or relative at Lennox Castle about them moving to a house, you can't assume that they'll understand what a house is. What you actually had to do was go to a house where folk were living and let them see it and almost let them touch it for them to understand what we were meaning. Almost without exception that turned people around and then some of the leaders of the Friends of Lennox Castle, when it came to their son or daughter, brother or sister in the process, they would change and acknowledge that it was possible. They were under a lot of pressure from hospital staff to be against it because their jobs and livelihood were at risk. In a small place like Lennoxtown it was like the local factory shutting, being the main source of employment there for a long time.

46. We would eventually get to a point where the assessment had been done, the commissioning had been done, when groups of people left together or some

individuals left. We commissioned one organisation in particular because there were some people who weren't going to go into groups or their behaviour told you they were not going to be groupable. We were able to do something a bit different and innovative through that organisation. It was easier in some ways for them because the housing that they had to get was so much smaller and self contained.

47. Ultimately you had to get the psychiatrist to agree that an individual person could be discharged, even though we were working in a situation where the hospital is going to close completely. The psychiatrist had the ultimate say and there was always a condition, for example, that people being discharged must have 24 hours support, even if in our opinion they didn't need it but we would go along with that and then start to help reduce the support once they were out.

48. When you go back to the assessment task, it sounds like it was a good thing to do, and it was, but at the same time, the information that you were getting wasn't particularly reliable. It was precisely that you were assessing someone in an institution and maybe their experience or knowledge of what's out there is very limited. They're maybe not getting to make choices about what they eat or what they wear each day and then suddenly new people are asking them what they want to do with their day and about living outside of Lennox Castle.

49. There is a story of a man who had a mild learning disability and lived in the East End of Glasgow with his granny. She was taken unwell and he was taken into Lennox Castle when he was in his twenties. She went back a few years later when she was better, hoping to take him home but she was told that he couldn't leave there. By that time because of what had happened to him, being whipped away from his family, he was angry, frustrated, medicated and all sorts of things. That man left through our process in his eighties. By that time there was quite a lot of pressure on us to say that people of that age should just go to a nursing home. That particular individual was saying that he wouldn't be going into any nursing home and so one of the organisations that we were working with sourced him a house in the East End of Glasgow and he had about six years living there before he died. He had his lunch in the pub and was back in his element. The sadness of that is unbelievable, his whole life wasted. There

is a resilience in the human spirit that he was able to say what he wanted and live out his life on his own. That shines through many of these individuals but there is a huge amount of harm unnecessarily being done.

50. I had no sense that anyone wanted to go back to Lennox Castle once they had left. Some of the research that was done through the assessment process, suggested that no one wanted to go back. Not everyone wanted to continue living in a group home so that would change over time, or the group homes would get smaller. I've no doubt that it was a positive exercise and that there were positive results for people. However, it wasn't perfect by any means, for all sorts of reasons.

Layout and structure

51. Lennox Castle was characterised by there being a top site and a lower site and the top site was closed by the time I left. I think it reflects a previous gender divide where the women lived at the top and the men at the bottom or vice versa, although that wasn't the case by the time we were working there.

52. The campus was spread out over a large area and we were based in an office block at the foot of the hill there. Near our office they had introduced an area where family members could come. There was a café and some shops so you could buy certain things. It was like a mock shopping mall to some extent. It was relatively modern and quite pleasant. Lennox Castle was a long way for family to come. It could be two or three different buses for some people so once they got there, they could meet the person they were visiting in this area and it meant they didn't need to spend their time on a ward. There was also a bowling green onsite which the previous Secretary of State had ceremonially opened although I never saw it being used.

53. There had been improvements and modernisation to the exterior and interior of the wards. Individual wards had been built from new, some of them at least. The further you went up the estate the older it became, I think that was why we were encouraged to close that bit first. Some of the buildings were abandoned by then. The recreation hall, where they used to have dances and show films which petered out over time, was

disused. It's hard to remember what I thought of it then rather than what I came to think of it later. To this day I've got an aversion to seeing the Campsie Hills. I remember the day driving into work and hearing the review of the newspapers and this front page 'Sick for Sale' article in the Daily Record was being talked about in relation to our work at Lennox Castle. I had this sinking feeling in my stomach so I just came to think about the location and the environment as all terribly negative.

54. There was lots of space so for those residents who were quite autonomous, they could get about the campus. For some it wasn't a closed in environment but for other people, I think they rarely stepped outside their ward from one year to the next. They weren't being facilitated to get outside but the staffing levels probably wouldn't have allowed that.

55. There were a number of locked wards, including more than one challenging behaviour ward. There is no good practice rationale behind putting a number of people with challenging behaviour together. It's to do with labelling people and assuming that the people who work in that ward will have more skills in dealing with that type of behaviour. But certainly in terms of people learning from each other, it's disastrous. These weren't small wards either, maybe about twenty people in each ward so you can imagine one person setting off another, setting off another. That still happens now in our modern day equivalents.

Staff structure

56. Susan Brown was in charge of Lennox Castle. She was from a nursing background but was employed in a role similar to hospital manager or such and alongside her were two or three different psychiatrists. There had been other psychiatrists previously, but when we were there it was two or three male psychiatrists who were running the place. I never had an overall sense that one of them was running the place, but one of them had to have been I guess. Susan was the person that I dealt with mostly, although she didn't want the place to close. There were nursing leads within the hospital itself who would report to Susan. There were other professions represented within the workforce there; physios, occupational therapy and other roles.

57. The staff numbers for the establishment were probably quite low. They could have got more people in but I think what they were funded to provide was probably relatively low. You could have two people on duty looking after a dozen people, some of whom were very physically dependent.

58. I had a line manager within the new Glasgow City Council and that was my reporting level outwith the hospital, within a social work structure. Once every month we would all come together around the table. Susan and a couple of her colleagues, my manager and I, someone from the health board would be there too and it would be a progress report. Quite often that was quite a conflictual meeting. I would be up against the health board representative who had responsibility for the oversight of the process of Lennox Castle closure and he was very much of the opinion to get people out as quickly as possible. He was prioritising whole wards being shut as quickly as possible because that was where savings were generated, whereas I was interested in the people, who they were and what they might need to live in the community and getting it right for them.

Recruitment, supervision and other staffing matters

59. I didn't have any personal knowledge of staff recruitment, supervision or any issues arising in relation to staff whilst I was there.

Policy

60. There would certainly have been such things as policies and procedures in terms of care practices etc. Certainly by the 1990s there were reformed nursing practices and a lot of good intentions behind that to improve things. So undoubtedly there would have been a standard of professional conduct that would have been expected to be met. The downside of that is that Lennox Castle was such an isolated, inward-looking, out of the mainstream entity away from everything else but ideally, professional training and continual professional training would have been emphasising the standards of professional conduct.

Children and routine at Lennox Castle

Admission to Lennox Castle

61. At one point in time you could have potentially gone into Lennox Castle at birth if there was a disability evident. You also find there are lots of admissions around the transition stages; birth, school age and puberty. For lots of young men particularly, that's a crisis time and often in people with autism, when hormones kick in, behaviour changes. Those transition points are quite key.

62. There were still admissions happening when we were working to close the hospital. I remember a man called [redacted] being admitted. He was a young man possibly a teenager or in his early twenties and he was admitted during that period despite the fact that it was closing. With a bit of imagination they could have commissioned a service for him that didn't involve having to come into hospital and then back out again.

63. For those being admitted to Lennox Castle the reasons for their admission would be fairly basic, like a cry for help from a family member or social work team. My understanding of the admissions process would be that my social work colleagues in area teams would refer people to the health service, saying that a particular individual needed support or they needed assistance. That was still sometimes resulting in admissions, not many though. The doctor might initially start from a position of saying that we're not making an admission and then ultimately a view is taken that there is nowhere else for them to go. Once admitted, there would be a multidisciplinary team that would look at that. Psychology as well as psychiatry would be involved but the person would always run the risk of being medicated in a way that they hadn't been up to that point. That was part of the treatment and part of the concern.

64. There was assessment going on continuously; assessment meetings, case conferences, admission meetings those sort of things and it was possible to get in there and voice your opinion which could lead to some therapeutic treatment. From our end, we would try to get involved and try and resist admissions or continued stay,

asking for the reasons but it was usually to do with behavioural issues that weren't being coped with in a community setting. If it came to the point where someone had to be admitted to Lennox Castle, it probably wasn't for therapeutic reasons, it was more for reasons of containment at a time of crisis.

Mealtimes

65. I didn't directly experience mealtimes at Lennox Castle, however, I draw comparisons to the daily routine from my experience at Kirklands Hospital when I later was involved with Support for Ordinary Living. In the early days before I was supporting anyone, my colleague Gina and I asked if we could go into Kirklands just to experience the routine of those we were going to support. We were both from a social work background but with the time I spent at Lennox Castle, I had had that direct experience of a large group of people, pretty dependent people, and people who couldn't communicate much.

66. By the time I got there in the morning I think they were up out of their beds and were sitting at the breakfast table. They had bibs over them and I started, alongside other nursing staff, helping to feed people because they couldn't feed themselves. While you were feeding the person, conversation started amongst staff about what they were going to wear tomorrow, never mind today. The day was get up, washed, dressed and fed then you were moved off to the lounge area where you would sit. It was a really valuable experience to observe this. Although we were a bit hands on at that time of the day and lunchtime, during that middle part of the day and afternoon we were participant observers. Nothing happened, the TV was on or there was music playing in the background. These were young people in their twenties or thirties, there was no stimulation for them.

67. Staff were not interacting with the people, they were interacting with each other. They were busy on administrative or other tasks. Unless you made a fuss or a noise you're not going to get any attention so you can see why there is challenging behaviour. I don't know that they had the allotted resources to do more but I came away feeling that staff could have been more personally engaged with the people. There were lots

of work related tasks to do but for five or ten minutes they could have spoken to some of the individuals or taken them outside for a walk or something like that.

68. That's my understanding of what the daily routine at Lennox Castle was too and from what I've heard second hand. For some people, this daily round of personal care or washing and dressing tasks constituted their lives. It's quite shocking when you see it and feel it. You begin to share what their experience is. The underlying assumption is, it's almost like they are not experiencing anything, not fully human or something, there's nothing much going on in the head or heart.

Sleeping arrangements

69. In Lennox Castle, it was still long wards and rows of beds, no curtains between beds and very little privacy. We had a photograph that was taken in the 1980s of a long Lennox Castle ward and when army people see it, they liken it to barracks. It wasn't as bad by the 1990s but there were minimal improvements, maybe fewer people on the ward and a little bit more space around the beds.

Washing and bathing

70. With regard to washing, I think by that stage things were much better in terms of privacy. I don't think it was ideal but there had been enough instances in the past of staff being disciplined for grossly invasive treatment, leaving toilet doors open and not caring about privacy or dignity. I'm sure bits of that would still happen but by and large people were much more vigilant about that and knew it wasn't acceptable.

Personal possessions

71. The whole laundry system in those big institutions tended to result in a lot of confusion about what belonged to whom. I've heard about clothing going missing or getting mixed up at Lennox Castle. Linking it back to my time in Dingleton there was a woman who visited her sister who, from time to time, would come for a period of respite care. Even in those short periods of visiting she would complain to me that she could see

that her sister wasn't wearing her own clothes or her own clothes had gone missing. I think it was a similar story across the institutions.

72. I've no direct experience of people having other people's false teeth in but I'm told that it was quite a common occurrence at Lennox Castle.

73. I wasn't aware of people having their own personal belongings and storing them within their wards. I'm more aware of people leaving with a black bag, that was it. It wasn't really like you could store your possessions, there was really no security around your personal possessions.

Leisure, trips etc.

74. I think there were trips out in minibuses, a dozen people or so in a bus. It seemed that they drove about and you wouldn't necessarily get out of the bus. Again, it was probably not sufficiently staffed to let people get out of the bus and to support people properly. It was almost a wee run in the bus rather than a constructive activity.

75. I did hear about a story from the person who was doing the equivalent of my job at Gogarburn where one day a group went out on a bus trip and when they got back they were dropped off at another ward because their ward had closed while they were out. There was no explanation or notice, they were just moved ward. I think the hope was maybe that they wouldn't notice and that highlights the underlying assumptions about these people.

76. There wasn't much going on for them in relation to leisure time. There was the bowling green that I never saw being used and there were probably other facilities on site that could have been used, but weren't.

Healthcare

77. Although it was still called a hospital, the hospital part had ended and there was no medical treatment. Across Scotland all fourteen of the establishments were still called

hospitals, they all had that name, were run by medical people, but there was no medical care.

78. I don't know all the ins and outs of it but it seemed to me that people were quite neglected in terms of their physical care. As an example of this, at Support for Ordinary Living, we started supporting a woman who had come from Kirklands Hospital. She'd only been out living in the community for a week or so before we realised she was in pain. One of the things that had to happen when they left those institutions was that they had a right to registration with a GP so as soon as they came out, one of the first things they would do is meet with a GP. This particular woman, when she met with her GP, they quickly diagnosed a fracture in her leg, her femur I think. From my view, that's the extent to which people's health care was catered for. Although you are in something called a hospital, you are getting less care than if you were living in your own house with your mum and dad or in your community. Lots of people can't communicate that they are in pain, they can't tell you so you have to be even more on top of things to know that they might be in pain.

79. Medication reviews would largely be a medical thing between the psychiatrist and the ward manager. There would be ward rounds by the psychiatrist and the nursing team and I think they called it the 'cardex'. That focused on medication and it was lots of psychotropic medication rather than medication that might be more to do with more ordinary typical health care issues.

80. I'm not aware of the use of sedatives at Lennox Castle in an informed way that I could assert, again just from tales that I heard. People would tell you later on that if there was a conflict, a bit of dispute going on between two people, the nurses would be in, you'd be pinned to the floor and the syringe would go in. I think some of the medication would be stuff that wouldn't even be used now.

81. C-Change for Inclusion undertook an art project with people who were supported by them, some whom had been former Lennox Castle residents. In the course of that project those people spoke about sedation. I remember going to an event when the art exhibition was being launched and there was discussion then about their

experiences in institutions and people told their stories of being restrained and sedated.

Schooling

82. There weren't any classes at Lennox Castle and I wasn't aware of any attempts at learning there.

Chores

83. There were some Lennox Castle residents who got jobs around the hospital but they were not paid.

Visitors

84. Lennox Castle was quite far away and was difficult to get to for lots of families. Visits were welcomed if they could make the journey and I don't think that it was frowned upon or restricted in any way, it was just the location that was the issue. I wasn't aware of any journeys being made in the opposite direction. In terms of visits home being facilitated, I don't think that happened at all.

85. I think bonds did form between families and members of staff and they were not altogether healthy. It created a collusion to some extent around maintaining the institution. That was much more understandable from the families' point of view rather than the staff.

Discipline and punishment

86. I was aware, as a practice, of privileges being withdrawn as a form of punishment. I wouldn't be able to specifically say instances of that happening. As far as I understood it that seemed to be part of the culture. Their right to go down to the café, for example, might be withdrawn.

Restraint

87. I don't have any specific knowledge of the use of restraint but my assumption is that it would have been enforced and it would be happening. Anecdotally, from former residents I would hear that people were being restrained and medicated at the same time.

Concerns about the institution

88. During the time we were there, human remains were found in the grounds towards the gateway at the entrance to Lennox Castle. The remains were later identified as someone who had gone missing some years before, someone who had had a bit of autonomy and was able to go out on the bus. The assumption was that he had gone into Glasgow and had disappeared. That was quite disturbing that so little had been done at the time he went missing. There was an investigation at the time the remains were found but there weren't any repercussions.

Allegations of abuse and abusive practices

89. There was a woman in one of the challenging behaviour wards who had come from the family home in Drumchapel and the strong feeling was that she had been abused by her mum and dad. I think she came in as a teenager, possibly still technically a child. I remember going to the family home to meet mum and dad and other social workers going before me. She had minimal communication skills but she was telling us in the way that she could, that she didn't want those people near her. They were still insistent on coming to the hospital to visit her. That was quite a heightened experience for all of us until ultimately the family were told that they must step back and court proceedings followed. She moved out with Inclusion Glasgow and is still living with support from them now and her mum and dad are completely out of her life. There would be other people like her, although her communication skills weren't terribly developed, through her behaviour and other cues she made it clear that there was something going on.

90. I've heard some hair-raising things in terms of abusive practices. They are uncorroborated from certain individuals about things that they witnessed or were subjected to in a sexual manner. I have no reason to doubt it but on the other hand I have no way of saying yes, that it did happen.

91. A former resident [redacted], told me of abuse that he suffered. He was forced to watch a couple having sex. I've no way of corroborating that, however. Things that have happened to him over the years may have become confused and conflated. I'm sure that he saw quite a lot of things or was subjected to a lot of things.

92. From what I understand, [redacted]'s sister grew up in Lennox Castle at the same time as him but they didn't know each other until he came out and was being supported in the community and was reunited with certain family members. It turned out that she had been there all the while that he had been there.

93. My father-in-law was a plumber and told me a story of when he did a job at Lennox Castle to renovate the plumbing in the 1970s. He proceeded to tell me the horrific things he'd seen in terms of people being virtually hosed down instead of bathed, in front of each other or people going to the toilet and the doors being kept open. I tried to encourage him to report that, but it was obviously from years ago. That was the kind of environment then. I think he was shocked by the indignity of it, the lack of privacy, having those private things happen communally.

94. I have heard a number of stories of women, although I'm struggling to recollect names, but you would go in to the likes of Lennox Castle to have your child and the child is taken away from you. These were women who absolutely had decision making capacity, there's no doubt about it. They may have had a mild learning disability but the system possibly treated them as lacking that capacity for convenience. That separation without thought or consideration is abusive, even just in terms of people's rights not being respected. However, I don't know enough about that process but it's really interesting how they got around that formal process, who consented on their behalf to give up their children?

95. My overwhelming sense of places like Lennox Castle was neglect. Not so much high profile incidents but a general culture of neglect. Whether it was the daily routine, the lack of stimulation, the low expectations that people are held to. This is an environment where your humanity is really in question. It's that all pervasive abuse and neglect. I read something the other day where the United Nations said that institutionalisation is an assault and I hadn't ever really thought of it in those terms but the UNCRPD are defining it as an assault. But it is that kind of assault on all your senses, your well-being, your citizenship.

96. There was a real lack of general medical care and personal care. I don't think anyone would dispute that. People rarely went to hospital if they had a medical condition. It would happen, for example, if someone had to go to hospital for an operation but not routinely. There were visiting GP's but no one who was personally attached to individuals, they were attached to a ward rather than a person.

Reporting of abusive practices

97. There would be whistleblowing channels open to people who worked there and agencies like the Mental Welfare Commission that people could have reported things to. Although it was rare for the Mental Welfare Commission to take up specific cases, that was my sense of it. They looked at more systemic abuse or practices. I don't think the Scottish Human Rights Commission existed in those days either.

98. You could probably have made a complaint to the local authority or health board but that would be less well understood. If you were a member of staff you knew there was a route you could go down by reporting to your senior, but you would probably go down that route with a bit of trepidation because that might backfire on you, however it was a route that was open.

99. If you were a relative or family member you could complain to the hospital manager, Susan Brown, if you had exhausted your dissatisfaction at a ward level. If she thought something really bad was happening I'm sure she would have acted.

100. I don't think there was a channel for individuals to complain because of subordination and dehumanisation. They weren't choosing what to have for their tea never mind complaining about their treatment there. They were just surviving from day to day, that's the way I would understand it. Attempts could be made to raise their awareness of their rights in a more proactive way but I don't think that was happening.

101. I think some of our staff when they got into ward situations would, if they felt things were not right around an individual, maybe try to raise awareness of a concern with ward managers. Some of that was fine but some of that led to strained relationships between our staff and hospital staff.

102. There is also a concern that some people didn't acknowledge or understand that what was happening to them was abuse. There were some people who knew that this was an injustice or that things that were happening to them were not right, but equally there were some who didn't. At a very basic human level perhaps they would understand that this is cruel or they were unhappy. But in terms of conceptualising that as an injustice, some were maybe coming to accept that this was part of their lot there and that this was how life has turned out for them.

External monitoring

103. There was a chief executive called Tim Davison and during the time I was there, there was an inspection report. I can't remember the name of the body that went around the hospital doing the inspections, but that body carried out an inspection at Lennox Castle and thankfully it was quite damning of what it found. It was an independent team of people that was assembled each time, to come in and do the multidisciplinary inspection and write up their findings.

104. Tim Davison spent weeks and weeks, and did eventually succeed, in getting that report modified and toned down in its criticism. There was a lot of politicking that I knew was going on through informal discussions but I wasn't involved with directly. He was negotiating with and trying to influence the inspectors and the general manager

who was in charge of the Health Board, Tom Divers. Tim Davison was quite a careerist and knew the reputation was going to be bad for him and for the Trust, so even though it was true what these people were saying, he worked hard to get the report changed. The final report was not in its original terms and was watered down a good deal.

105. At one point, there was a medical person who came in, I'm not quite sure of her status but she carried out a study around the extent to which people had their dental care, visual care and audiological care taken care of. Although this was a hospital, none of that was happening. People weren't getting the basic primary healthcare service, never mind secondary or social activities. The outcome of her study was negative, although I can't remember much about it. I think she was possibly doing an article for a journal.

106. The Health Board had some responsibility for the performance of the health Trust so there may have been mechanisms that existed there between the Board and the Trust for monitoring the performance but they would be quite distant, fairly arms length. There was a divide between those two entities, the purchaser and provider split.

Record-keeping

107. My colleagues would get access to the patient records when they went to do the assessment or commissioning work. They would often report that there would be a lot of recording about day to day things, medication and things like that but within those nursing records, not a lot about the person, who they were, their history and things like that. There would be separate medical records too.

Police investigations/criminal proceedings

108. I wasn't aware of any police investigations at Lennox Castle and I haven't ever given any statements about my time there.

Former residents of Lennox Castle

[redacted]

109. [redacted] was in Lennox Castle and only died quite recently. He'd obviously been there since he was a wee boy as we came across a monograph in the library, a slim medical volume, all about [redacted]. He had a particular medical condition and there were photographs taken of him from all sorts of angles because of the shape of his head. This wasn't done for everyone, [redacted] was a bit of a specimen in a way as a wee boy. By the time we got there, nobody really took that type of interest in him anymore. [redacted] had developed a life for himself around the hospital. He was one of the people who went from ward to ward doing wee jobs. He would maybe have responsibility for delivery of wage slips to the wards and that type of thing. It was interesting that he had carved out a niche for himself, not many people were able to do that.

110. He was one of the few people who said to us that he didn't want to leave. And we had to grapple with the fact that we knew that he had to leave. His verbal communication was quite limited, mostly he would say yes but he was able to say no. Those were his two main words. But he didn't need a lot of support, he was ranging about the place. He eventually did move out and although he had a reasonable level of support, he had time on his own which he enjoyed. His story is really interesting as he loved being out once he'd left. He loved going out socially and doing things he'd never done before. On his birthday he'd go out to the pub and was up dancing. He must've been in Lennox Castle since the 1950s as a boy so had spent a large part of his life in there, leaving there around about the same time I did, so in the 1990s.

[redacted]

111. [redacted] had been in Lennox Castle since the 1980s and was probably quite young at the time he was admitted. He had a supportive family but things had got out of hand for them and he was admitted. [redacted] was blind and was in a challenging behaviour ward. He had a reputation for biting people. This was what I learned through the assessment process. He would be placed in the corner with his back to everyone

else. He had no idea what was happening. Other patients would come up from behind to antagonise him and he had this defensive reaction of biting and he was notorious for it. There was a spiral here, I think they kept him in a corner to keep him away from others but it caused his behaviour. There was no rationale for it from a good practice or wellbeing of individuals point of view, it's the reverse of what you should do. The thought was that someone like him would never get out, if the hospital closed he would go to another hospital but that wasn't the case.

112. We did the individual assessment process and he got his own house, staff got special training to work with him and got to know him as a person. In the early days somebody did get bitten but that was a behaviour that faded away. He has now been living in his own house in Ayrshire with support for years, but for all those previous years he was contained in this chaotic environment and was biting people. My colleague, Francis Brown, was telling me that she was his support organisation's office recently and in came [redacted] with his support worker all these years later.

Leaving

113. Another part of the story and probably part of the reason that I moved on was that in about 1997 on the front page of the Daily Record one morning out of the blue, was the headline 'Sick for Sale'. This was an extremely negative article about our work, that we were somehow selling off the sick to the lowest bidder. The article was inspired through an alliance between the local MP, the Provost of West Dumbarton and Unison. Ironically, I was a member of the same union at the time. They had planted this story in the public domain. In my role in the project I became really stretched between the Trust and my social work managers on the one hand, who were wanting it done quickly and cheaply and adding in that political agenda, and on the other hand my professional accountability to the men and women who lived at Lennox Castle. Add in the pressure from those who wanted Lennox Castle to remain open to protect local jobs, it all became very stressful. It was what drove my colleague, who was the manager of the commissioning team, and I to set up Support for Ordinary Living. We went to the other side, the service delivery side of things, rather than continue to be caught up in all the machinations of the bureaucracies.

Former residents of similar institutions

[redacted]

114. Whilst working in the Borders I met [redacted] who had lived with his mum and dad in Alloa but sadly they both died. Up until that point he'd had a job in the bottle factory and was living fairly independently. Suddenly he found himself admitted to the Royal Scottish National Hospital in Larbert. By the time I met him, several years later, he was living in an unstaffed group home in Galashiels.

115. He was Charlie Chaplinesque type figure and would go around the charity shops in Galashiels and Hawick. He was full of tales from his days in the factory and was always cracking jokes. I'll never forget dropping him off one night at his house and he asked me if I knew what happened if you took ill while building the Great Wall of China. I told him I didn't and he explained that they just built the wall over the top of you. I was still waiting for the punchline of the joke but he said that sometimes he thought that was what had happened to his life. You're at the point where you are a forty year old man by then, your parents have died and you have to forget your job and find yourself going into Larbert Hospital.

116. He told me about sitting down to eat his first meal in that place and he got slapped because he had started to eat before he was told to. The environment was such that even the food that was provided to you had to be guarded from others and you all had to eat at the same time.

[redacted]

117. Again, from my days in the Borders, I met [redacted] who had gone into Gogarburn in the 1950s or 60s to have a child and ended up staying there for a long time. Her child had a disability and grew up in Gogarburn but there was no relationship between them. I knew [redacted] as an adult woman later in life, post Gogarburn, when she was living in

the community and was getting married. She had only found out much later on that her child had grown up in the same institution as her.

118. For [redacted] to have been admitted to Gogarburn to have her child would suggest that she didn't have a lot of family around her at the time and was quite vulnerable. There wouldn't have been a lot of advocacy around her so she didn't necessarily know what happened to the child at the time. The child was delivered and taken away but I had no sense of her formally giving up the child for adoption. You would think there must have been some formal process in the background but maybe she wasn't involved because they didn't think she had the capacity.

[redacted]

119. [redacted] was a resident in Birkwood Hospital, Lesmahagow. He was a wee scrap of a man and was all bashed about, he had ears like a boxer's. This man had gone into care as a child and he was in his forties when he left. [redacted] and another man had lived in the same ward together for years and years as children. Here they were in their forties, the hospital was closing and our organisation had the job of supporting him. He had a really good social worker who we really trusted. She'd done the assessments and we understood that they were really good friends, so we organised for them to live together in a house. I went away on holiday and came back to find that [redacted] had been knocking lumps out of the other man almost immediately. They might have been able to live together on a ward for years but sharing the intimacy of a domestic setting was a different matter. [redacted] was very aggressive towards this other man and towards other members of staff at the time until he got settled in.

120. We were determined that he wasn't going back into hospital and he went into homeless accommodation for a few nights. We'd go and try and support him there and then he got his own house. Then we learned what he did at night even when he was living on his own; he put his possessions, coins and keys, down his socks and even Irn Bru cans were concealed under his pillow. He was absolutely untrusting of anyone and everyone. I think you had to guard your possessions with your life if you were in those

institutions. For the likes of [redacted], he had all sorts of devices to make sure that what he valued was secreted around his person or in a place that nobody else could get to.

121. Ultimately however, he started getting supported by people who got really close to him and got to know him really well. One of the members of staff who was supporting him had a new baby in their family and there is a photograph of [redacted], this wee boxer, holding the baby. It's what makes this kind of work really worthwhile when you see things like that. It also gives a lie to the people who would dismiss those like [redacted] and judge them by their reputation. Here he was being gentle, sensitive and smiling. I remember at the time thinking that there was something about the human spirit there. You should never write anyone off. Despite what's done to you, you can still come through and you're not necessarily finished or written off.

Other institutions

122. There was a fair similarity across lots of these long stay learning disability hospitals. I have been in Ladysbridge in Banff, Woodlands, the Lanarkshire Hospital, Merchiston and the Royal Scottish National. They all came from the same sort of roots and a social policy from the 1930s. That's their core and they were dragged into the modern world after the war.

123. Lennox Castle had a reputation for being worse than others. It may have been but I was never based in any of the others for any length of time to say. Probably more than most, it had that sense of being where local people worked. Ladysbridge in Whitehills near Banff was a bit like that, one of the main employers locally and that in itself led to some insidious practices. You had someone whose mother, and their mother before them worked there. There is a strong loyalty to each other in such staff groups. That would certainly be a barrier to whistleblowing.

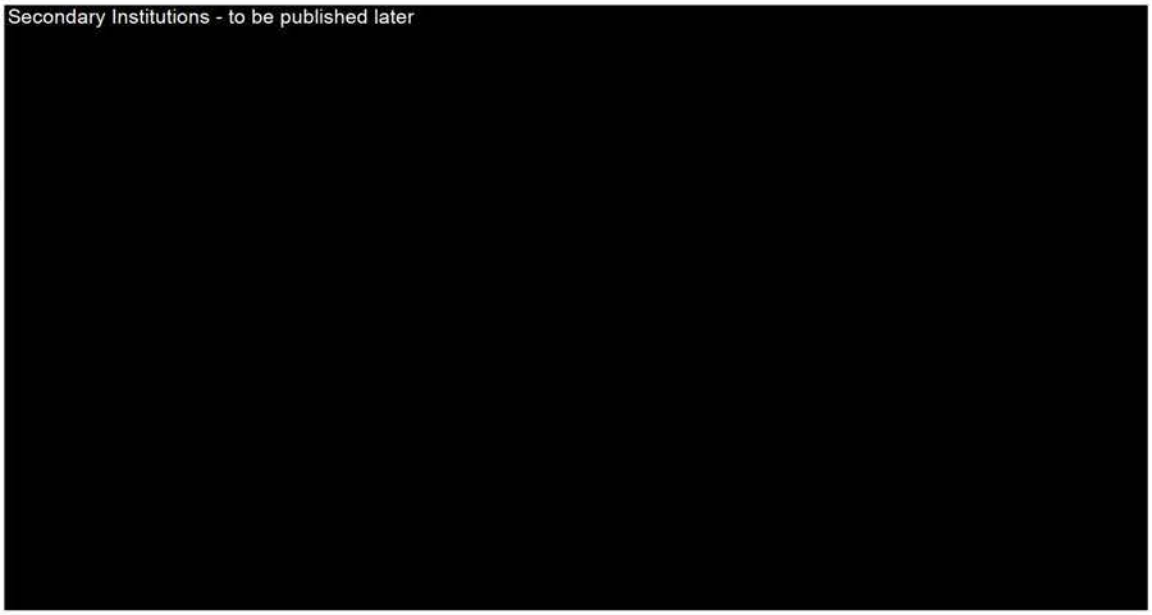
124. The workforce in Gogarburn would have been different, a bit more cosmopolitan and a bit more varied in where they lived and how much they relied on that place to provide their livelihood.

125. As an example of that staff loyalty and dynamic, I recall that when I was first qualified as a social worker and went into an area team back in the 1970s my senior social worker and line manager came in with sixty-five cases under his chin and plopped them on my desk and told me to get on with them. He turned out to be a man who was in the pub as soon as it was open every day. There were two or three of us in that position, in our early twenties, in the East End of Glasgow with these huge expectations placed upon you. You couldn't get hold of your line manager and if you did get hold of him he was clearly inebriated. The disapproval that we brought on our heads by drawing that to the attention of his manager, who obviously must've known, was unbelievable. We were seen as being disloyal to Bob; not that we were looking after ourselves or were concerned with standards of practice.

126. Secondary Institutions - to be published later

127.

128.

129. 

Helping the Inquiry

130. There was a study by the Scottish Office in 1987, 'The Study of the Balance of Care' which said that for every person living in a learning disability institution at that time, there was an equivalent person already living in the community. It gave the lie to the fact that some people needed institutions. If that's true, and we know that institutions damage people, you think that would be acted on in policy terms. Why are we not acting on that? There's a systemic abuse at that level. We don't bother about policy at governmental level and we still persist in institutionalisation. Some of the reasons given for not doing so would be on grounds of cost and they would say it's too difficult. I think that it's basic discrimination. There is an underlying subconscious bias. We might understand at a rational level that it's true that institutions are unnecessary and damaging, but it's not sufficient of a priority for the authorities because these are people who are less important. They don't have the same value as you or I. That's my understanding of it.

131. Mostly children under the age of sixteen don't end up in institutions but I think those transition points are key. The transition from childhood through to adolescence is the point at which young people find themselves admitted to institutions. Families or social

work approach healthcare and they don't necessarily say you need to take my child away but they approach the services for help. Then they quickly find that it is recommended that their child goes to 'X' for assessment and then they don't quickly come back out of the system. This is a particular issue for younger men with autism, or a learning disability whose behaviour challenges the systems and they quite quickly get medicalised and drawn into a mental health world rather than a learning disability social care world and that's still happening.

132. It has felt like almost like two-way traffic. All of these people were coming out as part of the hospital closure programme, but at the same time there was another group of people going in the opposite direction. As those hospitals have ceased to exist, other types of facility have been there ready to take them or have been created. Or they exist in England somewhere and you can be sent off to a unit in England where it's believed they could cope with you. The Government commissioned a report, the 'Coming Home' report, that identified at least seven hundred people who were living in institutions and were out of area. There was a big undertaking to do something about this. There were targets set for last year which were never remotely met. You can have children under the age of eighteen moved to England with their family still living in Scotland. Family contact becomes difficult, the relationships are already under stress and they get further and strained and distanced. There are also NHS and private sector institutions in Scotland that help this damaging model to persist.

133. In my current role at Radical Visions I'm working with a family of a boy, [redacted], who has ended up in Carstairs. He got into a bit of trouble when he was nineteen with the police. He was supposed to go to a medium secure place for a short time. There was no availability but there was space at Carstairs. He's 28 now and he's still there. He could easily have been seventeen or eighteen and caught up in that kind of system. This situation is consistent with those families who find they are struggling, then ask for help and then have their child detained under the Mental Health Act quite quickly thereafter. It then becomes extremely difficult to get them back out.

134. [redacted]'s mother told me that when he went into Carstairs they gave him all of these different kind of medications over the years. They drugged him and destroyed his

reputation as it were, he's very dangerous according to them. The relationship between him and his mother is non existent. It's partly because [redacted] has worked out that he'll be better treated in there if his mum's not having too much influence on what's happening. Right in the early days of that placement, some staff had to be dismissed because they were being cruel and nasty to [redacted] and there was maybe some physical restraint too. She was part of the agitation for all of that so she got a reputation. Every time he's asked what he wants to happen he says that he wants to go home but in the next breath he says that he doesn't want her to come to the next Care Programme Approach meeting.

135. Institutionalisation is a vicious circle. You can go in with a reputation for being deviant in some sort of way because of your behaviour or disability. You are then segregated and maybe put in a ward with people who have the same issues as you, so you lose some of the skills you already had. You're viewed further in a negative light because of that and you spiral down the way. You go in there for treatment but you get worse. Almost all of this particular man's adult life has been spent in there but if he'd been convicted of an offence he'd have been in and out of jail by now and little of that damage would have been done to family relationships.

136. Through working with this family, we've managed to get to a point where it's been agreed he could now move on but they want him to move on through a ladder of succession of institutions; go from high security, to medium security and so on. But again going back to good practice, you don't do that. You take the person as they are and build the support around who they are and if that changes over time then that's good but you don't wait until they 'learn'. The authorities have grudgingly accepted that they'll listen to a way of doing it differently. You could imagine that by the time you come down that ladder, another nine years could have passed.

137. All of this is set in a policy context set as far back as the 1990s. Jim Mansell, a professor at the University of Kent, was commissioned by the Home Office to write a publication detailing the best policy for those with autism, learning disabilities and/or challenging behaviour. At that time he said that people just needed a home to live in and the proper support. It's no more difficult. Staff need to be properly trained and it

requires sustained commitment. This is the best way and has the best outcomes for people.

138. In the mid 2000s the Home Office came back to him and asked him to write another report on the same thing but he just wrote the same report a second time. Nothing had changed. There is a failure to accept what the evidence is or what good practice looks like because the authorities want to keep on doing things the same old way. Institutionalisation continues and that's why it feels like systemic abuse. There is a systemic denial of human rights. If you work in this field everyone knows that institutions damage people, everyone knows that Mansell wrote those reports and would write the same thing today if he were still with us.

139. The Scottish Human Rights Commission, in January 2025, published the 'Tick Tock' report and the arguments found there are amongst the strongest yet published in defence of independent living. It's ammunition that we've not had expressed before in such a powerful way within a rights context. We will be trying to put all of that to maximum use.

140. The worry is, from the work that we are doing just now, that this is a persistent abuse. Institutionalisation itself is an abusive practice. The recent report quotes some opinion from the Committee on the UNCRPD about institutionalisation being an assault. It's not acceptable for anyone. If you combine that with the Mansell reports, we have no excuse for continuing to do what we do. People should be going into hospital for short periods of treatment, not to live out the rest of their lives.

Lessons to be learned

141. We need to be proactive and preventative in our approach. Prior to those red flags starting to go up around those transition phases, it's knowing that that may be likely to happen for some people so when they are thirteen or fourteen, anticipating and implementing early interventions. It shouldn't just be reactive and then everything

becomes urgent but there is no real evidence of that happening. There's less and less of it happening, partly due to the de-funding of social care if you want to call it that.

142. As an example, we not so long ago had a woman with a learning disability who had a son. Her disability was quite mild and her son had autism. They lived together happily through pre-school, primary school, and there was an extended family, a sister, who kept an eye on things too. He was coming up to the age of fifteen, sixteen and he started to be physically aggressive towards his mother and she was the last person who could cope with it and she found it really difficult. The child's social work team started to say to her that she was bad mother because she was rejecting him. However, she wasn't rejecting him she was just saying that something else needed to happen as she couldn't cope. I was acting on her behalf and on behalf of her sister to say to social work that they needed to look after both mother and son in their separate ways without demonising either of them. It was very difficult, and there was some very prejudiced thinking. I'm not sure why, possibly partly because they were both disabled.

143. We managed to get social work to support her move out into other accommodation and the son stayed in the accommodation they had previously shared. The social work team brought a social care organisation in who were really not equipped for the task. They kept making medication mistakes, didn't know how to deal with his behaviour and it was really difficult to persuade social work that they had messed up and hadn't done their work properly. They wanted to put him in a foster placement and that was really difficult for his mum to even think about some other family looking after him.

144. However, he now has his own accommodation, has a different provider and last time I checked things were going well. He could easily have been one of those casualties who end up in an institution and disappear. It's bad practice, bad attitudes and lack of knowledge.

145. There is legislation that governs social care in Scotland since 2013 called the Self Directed Support Act (SDSA). All social care in Scotland is governed by this Act which allows people to be more in control of their own support arrangements and have different options to choose from regarding how the funding is managed. I wouldn't say

it's universally ignored but it's largely ignored. There is no accountability so unless people like ourselves are involved to point out what the SDSA says, or what the statutory guidance compels them to do, if you don't have that behind you, they just ride roughshod over it.

146. I feel like I'm generalising saying all social work practice is bad but so much of it seems to be dictated by the need to save money, or by the feeling that we don't know what to do with these people, or we've never really understood the Self Directed Support Act anyway. The SDSA has a human rights base and says that the purpose of self directed support is to promote independent living. There is a definition of independent living given which has it's roots in the disability rights movement and says that it's not about living on your own, it's about having all the support that you need to live at home; in education, at work, in the community, as a member of society. However, social work want to say that they can only afford to provide support with personal care, the rest is a bit of luxury. I don't think you should make the assumption that independent living is cheaper than institutional care. But as Mansell himself pointed out, it's no more expensive either.

147. The level of care varies throughout local authorities. They are all under so much pressure at the moment and I don't get the sense that there are any shining beacons of good practice.

148. For a long time North Lanarkshire was performing well. However, some of those I'd previously worked with who had knowledge of and had caused a lot of positive work to happen around the resettlement of residents of Birkwood and Kirklands Hospital, seemed resigned to the fact that things no longer worked in the same way. Where they had previously promoted human rights, they appeared to have been unable over time to sustain this approach through partnership working. Whilst they would acknowledge some of what was happening was terrible, their ability to impact it had significantly reduced.

149. There's a trick that East Renfrewshire and other authorities are using at the moment which relates to eligibility criteria for social care. When funding is short, they say you

are only eligible for social care if your need is 'critical' or 'substantial'. But then what they are doing is using those words, 'critical' and 'substantial' to describe the support you will get. The criteria that are supposed to determine whether or not you get through the door are then being used, illegally I would think, to determine the kind of social care you can get. It goes against the SDSA, there's no basis for that in the law. They're probably only doing it because they are under such a lot of financial pressure.

150. What happens at local authority level is they adopt rules and regulations which are in opposition to what the law says but these rules and regulations then govern how they practice. Local authority policy is then in conflict with the national policy and law. We are the only country in Europe that's adopted self directed support in law, however where's the force of it being felt? I don't think local authorities are accountable to anyone, that's my sense. The proposal for a National Care Service might have changed that but Convention of Scottish Local Authorities (COSLA) resisted that. If you raise a complaint with an authority, you can't go to the ombudsman unless you go through the full complaints procedure. It's almost like marking your own homework; there are two or three stages and they just say no we've done ok here, your complaint's not upheld.

151. In his response to the Winterbourne View scandal, Mansell provided a quote which is relevant across all institutional care: "It's just the wrong model of care". It's an institutional model of care and it's just not going to work. No matter how much improvement you build into it, it's still going to fail people. There is still a clear disparity between what we know and what we do.

Other information

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

Signed… [redacted] ……..

Dated……24.4.25……