Friday, 2 May 2025

(10.00 am)

LADY SMITH: Good morning, and welcome to the last day this week in Phase 9 of our case study hearings in the section in which we're looking into healthcare establishments which made provision for children.

Now, we move to another oral witness to start the evidence this morning. I gather she's here, ready to go; is that right, Ms Innes?

MS INNES: Yes, my Lady. The next witness is Samantha Smith. She is the chief executive of a charity, C-Change Scotland.

Samantha Smith (affirmed)

LADY SMITH: Thank you for coming along this morning to help us with your evidence, particularly in relation to Lennox Castle Hospital, which you'll understand is one of the places that we're hearing about in this section of our hearings.

Easy question to start with: how would you like me to address you? I'm very happy to use your professional title, your first name, whatever you're comfortable with.

A. Just Sam will do.

LADY SMITH: Sam, thank you for that.

As we go through your evidence, we'll bring material

up on the screen that may help you. I see you also have the red folder there that's got what you signed in it, the statement that you very helpfully gave us in advance. It's been of great assistance to have that. Thank you for going through that process.

If you have got any questions at any stage, just speak up. If you want a break, do tell me. We hope, I think, that your evidence will be finished by about 11.30. But, if it's not, I always take a break at about that time anyway, if that works for you.

But, as I say, if you need a break at any other time, do speak up, because I know it's hard work being asked question after question, particularly in a public forum.

If you're ready, Sam, I'll hand over to Ms Innes and she'll take it from there; is that all right?

A. Okay.

LADY SMITH: Ms Innes.

Questions by Ms Innes

MS INNES: Thank you, my Lady.

Good morning, Sam.

A. Morning.

Q. We have a copy of a statement that you provided to the Inquiry at WIT-1-000001458. That's come up on the screen now. We see there that you give your name,

Samantha Smith, and your date of birth is in 1967; is that right?

A. That's right.

Q. If we could look, please, at the last page, page 32, I think we see there, at paragraph 159, that you say:

'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.'

We see that you signed your statement on 5 July 2024; is that right?

A. That's correct.

Q. Now, if we can go back to page 1 of your statement again, at paragraph 3, you set out your qualifications. You tell us that your initial degree was a joint honours that specialised in disability and you have some postgraduate qualifications as well; is that right?

A. That's correct.

Q. Did you undertake your postgraduate qualifications whilst you were working?

A. Er, yes, all of them.

LADY SMITH: Sam, I wonder if we can get that microphone into a better position for you?

A. I've got quite a soft voice, my apologies.

LADY SMITH: I think we've probably had it at the wrong

angle. See if that works.

A. Is that better?

LADY SMITH: That's better.

A. I can lean in a bit.

LADY SMITH: Thank you.

MS INNES: You were saying that your postgraduate qualifications were whilst you were working. In particular, you have a PhD, the title of which is 'Living with Risk'. You say:

> 'It looks at how adults with learning difficulties perceive risk, trying to view the subject from a different perspective.'

A. Yes.

Q. Can you tell us a little more about that?

A. Risk was a very important criteria in closing the hospital that I worked in when I was a commissioner, and it's a significant factor in how we treat and support adults with learning disabilities and -- adults and children with learning disabilities and autistic people. And it was my view that we didn't always take in all perspectives when we viewed risk, so that the perspective of people themselves were, I thought -- and I wanted to test -- maybe not the same as professionals or others involved.

So my PhD was looking to ascertain the perspective

of risk from a group of people who were deemed to be high risk by health and medical professionals.

Q. And when you say that a group of people were 'deemed to be high risk'; what was meant by that?

A. They would engage in behaviour that others felt caused concern. So there was a term 'challenging behaviour' at the time, which has a definition. Please don't ask me to recite that. But there is a definition that, at the time was agreed, by academics and clinicians, and those who worked in social care.

So the group of individuals had been -- they were part of this thing called the Robust Services Project, which meant that there needed to be particularly robust services to support them because of these perceived risks and challenges.

Q. What was the conclusion to this study?

A. Well, interestingly, that the individuals themselves had quite a considerably different perception of risk to the clinicians.

So I had the clinical notes and I had the views of the individuals. So, erm, one of the key findings was that people thought that the system that supported them was itself a risk to them. In particular, erm, one of the women, she felt that being supported in the same space as men, given her history of abuse, was

a considerable risk to her.

One of the -- gosh, in undertaking my research, I ran into my own assumptions. I think that's what academic research is meant to do. It, kind of, challenges you. So I assumed, initially, that people understood the labels that were attached to them; that they had a learning disability; that they were defined as being 'challenging' and that they understood they were part of this Robust Services Project.

Having undertaken my first lot of conversational interviews with people, I then ran into my own assumptions and realised I had to go back and ask people did they recognise this terminology; did they understand? I had gone through all the ethics processes and that hadn't been picked up by anybody else so ...

When I went back and asked people whether they understood that they had a learning disability, if they'd heard that term, most people agreed that -- in various ways, that they thought that had been applied to them in terms of the idea that they were 'challenging'. That was a very disputed definition. People did not accept that, and most people didn't know that they were part of this Robust Services Project.

So there's a whole system of support and structure that they weren't even aware of. I think that's not

untypical.

LADY SMITH: Sam, how do you feel about this expression 'challenging'?

A. Erm, I think -- one of the -- my respondents in my research said, 'If they didn't annoy me so much, I wouldn't be so challenging', and I think I kind of aligned myself a bit with that. I think the challenge should be on us to do better, not on -- it shouldn't be applied to individuals.

Because -- nobody wants to live in a state of continual distress and if, instead of seeing people's behaviour as something to control, we recognise it as a way of telling us the world is too hard, and that the onus isn't on the person to conform, but on us to do better, that the person doesn't get to that place.

LADY SMITH: Let me suggest this, because it's a word I've heard, as you can imagine, again and again in the work we're doing here: it occurred to me quite early on, that there was a problem with this word. I might find it challenging to me if a child 'kicks off', to use a colloquialism, or if a child seems to be out of control. I feel challenged because I feel I have got to do something that I'm finding hard.

The person who is causing me to feel that may not be challenging me in the sense of wanting to have a fight

with me or a battle with me at all. But, as you say, they're trying to tell me something. They're not doing it in the best way or the easiest way for me to understand.

And we have got to find a better word. I'm not sure I've arrived at the right word yet to capture what's happening when somebody in a position of responsibility in relation to a vulnerable adult or a child is having to cope with a difficult situation. I'm still trying. I don't know if you've found one?

A. The distinction, I think, that you outlined there is exactly correct. And I think what's happened is the distortion of the word 'challenge', it's been placed on the child instead of being held by the professionals in that circumstance.

And I think it's okay for us to feel challenged to do better. That's it. When someone gets to a state of distress where they do things that make it difficult for them and others, the question is: what could we do to make sure that never happens again?

And that's the bit we fail to do.

LADY SMITH: Or what could we do to help in the moment of crisis?

A. What can we do to help at this moment of crisis in a way that causes least harm, and, from that, how do we learn

and help ensure that doesn't happen?

And it's the learning and helping ensure that we do not replay this again, that child, that adult, never has to be in that circumstance again; that we try our hardest to extract every bit of information we can. And that's the bit we don't do, because we centre the issue on the child rather than on ourselves.

LADY SMITH: Thank you very much. That's very helpful.

Ms Innes.

MS INNES: Thank you, my Lady.

Now, if we can look down in your statement at paragraph 5, you say, around 1996, you took up a position as a commissioner at Lennox Castle Hospital after it had been decided to partially close the hospital. We know that the hospital ultimately closed in 2002.

Can you explain what the position as a commissioner involved?

A. We had, kind of, two teams that worked together. One team was an assessment team and they'd go and work with individuals and the ward staff to try as best as they could to find out how someone might be -- want to be supported outwith the hospital in community services, find out their, kind of, wishes and preferences, and also any particular information that might be relevant

to how we would set up their support.

My role as a commissioner was to take that information and then work with housing and provider organisations to set up contracts to ensure that organisations came in and supported individuals in the hospital to move out of the hospital into community resources, so that we could close the wards. And there was a resource transfer arrangement so that funds went from health to social work, to provide the social care support.

Q. How long did you remain as a commissioner?

A. I left -- sorry, I'm just trying to think how many days there are in April. I left in -- at the end of April 2001.

Q. We see at paragraph 8 of your statement, on 1 May 2001 you founded C-Change?

A. That's why I was trying to remember how many days there were in April. Yes, that's right.

Q. So you moved from being a commissioner to found the charitable organisation of which you remain the chief executive; is that right?

A. Yes.

Q. And what do you do in C-Change?

A. So I started the organisation because there were a group of people in the hospital that had these big reputations

for challenging -- using the term as we described earlier -- challenging services or challenging professionals, and there was a sense that maybe some of these people would have to move to other institutions.

I didn't think that was necessary, I -- along with others -- but I felt that if we supported people well, listened to them and then tried to, as that respondent in my research said, annoy them less, that we would be able to support people in their own homes and, importantly, do it at the same cost or less than it costs to institutionalise people.

So the organisation was set up to do that.

Q. Has that continued to be what the organisation does or has it moved on?

A. Yes. No, it's still the same. We are an explicitly human rights-based organisation, so we look to frame everything we do in the UNCRPD, the UN Convention on the Rights of Persons with Disabilities, particularly Article 19 around independent living. So we use the mechanics of the state to make sure that we provide our support in that way.

We believe that any money paid by the state is a person's individual budget, and we support people and we're accountable to them about how we work for them to deliver their support.

Q. So, going back to the time that you were a commissioner at Lennox Castle, if we move on, please, to page 3 and paragraph 12 of your statement, you mention that quite a few of the residents of Lennox Castle were not formally detained?

A. Yes.

Q. They were informal patients. And at the time that you were a commissioner, were the people that you were dealing with adults rather than children?

A. Yes, yes.

Q. And you say here that there was a distinction between those who had been formally detained and those who were informal. Does that mean that the informal patients could essentially have left at any time?

A. Erm, yes, except that they had nowhere to go and no support. So the idea of informality, if you've not got any state support, is I think -- it's not arbitrary, but it's -- it would -- I would be concerned that we misinterpret that, that people chose to stay. If they had an informed choice and the resource to do other, I think -- well, I know because when given the choice and the resource to do other, people left.

Some people were scared of leaving the hospital. I don't deny that. But, when offered a house and support, most people willingly left the hospital so ...

Q. And did people know that they were informally or formally detained? Did they have that distinction in mind?

A. Most people, no. Some people were aware. I can think of one person in particular, because he escaped and was returned and detained, so he was very clear. He spoke in the Lennox Castle Stories about his escape and return. So on that basis -- but there wasn't something where there was routine reviews where it would be clearly outlined to people in an accessible way that you are informal or detained.

Q. And when you talk about people being given the choice and then choosing to move to a house with support, at the time that you started the commissioning process with people; did they have an understanding of what it would mean to have a house and support and live outside the castle?

A. A lot of people, no, because they'd been in the hospital since they were children. So, when you ask somebody, 'what kind of house would you like to live in?', if you've only ever lived in an institution that means nothing, really.

So, erm, we had to spend a lot of time helping people know and understand what that would mean. So going out to -- the providers would mostly do this work,

supporting people to go out and look, and see a house and choose a house, and be clear about who they might want to live with. But -- so we did the best to make it an informed decision. But it's -- it's a huge thing for somebody who's maybe been in a hospital since they were -- for some people since birth. They grow a reality and understanding of that often in the doing of it.

Q. I suppose the impact of having been institutionalised is not only in relation to a house, but perhaps everything else that goes along with living in the community and managing day-to-day living?

A. Absolutely, but again, I would want to be really clear that one of the privileges of working to close a hospital is seeing the capacity for human resilience and resourcefulness and ability to grasp opportunities that haven't been afforded to people. There are -- and the reason I'm being quite particular about this is, oftentimes, the longevity of someone's stay in an institution would be the reason why they may be -- it would be argued they wouldn't be able to move.

Erm, that was not my experience. I think I spoke about one individual who had been in since the age of 13 until he was a very much older man, and he settled into his house in his 80s in a way that when I went to see

him, one month after he had moved, with his television on, watching the football in his chair, and he'd already, you know, found a local pub, because we did help him move near his nephew. We have -- we have a capacity to flourish in the right environment no matter how long we've lived in something that has been -- not enabled us to do so.

Q. Now, if we can move on to page 4 of your statement, at paragraph 18, you refer to other members of the commissioning team and I think John Dalrymple was the head of that team; is that correct?

A. That's correct.

Q. Then you talk about the liaison with the Health Board and you say that it wasn't an easy relationship; can you explain that?

A. Yeah. No -- yeah. Mm-hmm.

Okay. The trust ran the hospital, so the Health Board was the delivery arm -- so the trust was the delivery arm of the Health Board. Our relationship with Julie Murray, who was the Health Board link, was a very good and supportive relationship.

It was just it was quite difficult for people who had been running the hospital and thought they were doing a good job, to have a team of people suggesting it could be done better somewhere else.

So I think that's what I meant by it. It was not an easy relationship. They didn't always agree with people moving and there was certainly a sense that there should be some -- there was a plan, for example, for a white house to be built, which was a unit to remain. There was always that sense that not everyone should move.

Q. So not everybody should move into the community. Essentially, some people should remain in some maybe a smaller, institutional setting?

A. Yes.

Q. Over the page, at page 5, at paragraph 22, you refer to many of the people that you commissioned services for having been resident in the hospital since childhood, and you mention different points at which people appeared to have come into the hospital; that some had come in from birth, some at primary school start and some at adolescence?

A. Yes.

Q. Was that something that you observed: that there was this sort of pattern of when people came into Lennox Castle?

A. Yes. And the other one would have been at the death of a significant carer. So -- but, absolutely, when you read the case notes in preparation for supporting

someone to move, those would be the life markers for -- and there would be some exceptions, but the pattern was that.

Q. Was there any clarity as to why a person had come into Lennox Castle, in the sense of what their stay there was going to be designed to achieve for them?

A. Certainly for -- remembering there were some people who had been in the castle for a very long time, in the institution. So for -- we -- families were told at the birth of their children to 'forget this one, just go and have more children'. That was common.

So it was a place to put people who -- we had the long kind of shadow of eugenics. And so that was common that families were advised that their disabled children didn't need to go home with them and that alternative provision would be available, and to get on with their lives.

And there were families who resisted that. And there should be no judgment on families who found that really hard and did what they thought they were being told. And it made our job, actually, helping people to move, more difficult for families because they had been told by professionals one thing and then we, in our attempts to make things -- improve the world, were then telling them something else.

So there was a huge amount of emotion and guilt that if their son/daughter, brother or sister could live in the community and be supported now, as I was telling them; why not before?

So it would happen at birth. It would happen at going to school, just because that was -- that was another time when they would butt up against the system. And oftentimes in adolescence, because things that families had been able to cope with, erm, er, became more difficult when you overlaid some of the difficulties they were experiencing with emotion and then with the larger size of an adolescent. So that would be, again -- either, you know, the change in school or adolescence kicking in.

Q. If we go on to the top of the next page, page 6, at paragraph 24, you say that you had been to Lennox Castle Hospital before you started your role as a commissioner and you had done a music therapy course at the hospital before that. You said:

'I was shocked then and it remained a fairly shocking place to work.'

What shocked you?

A. Well, when I went to do the music therapy ... I had as a -- since I've been a teenager, actually, I was involved with the local -- in my town, my youth club was

an All Together youth club. It was for everybody. And there was -- so a lot of my friends were disabled people and some really courageous parents, who had resisted the -- being advised that their children should be sent away.

So I had -- and through that I had done -- kind of gone on holiday and we used to collect people from some of the institutions. So it wasn't my first time going to an institution. We used to literally go and get some people from some wards and then we'd go off on holiday for a week and do things. Then we'd drop them back at a secure ward. It was all very odd, when you think about it.

So it wasn't my first time going to an institution. But, when you walk in and you realise there are places where people live in these congregate settings -- so ...

And that they're apart and separate from. It was shocking at the time, when I did that course, again, 'cause you go home. You realise you're leaving people and you're going home.

Working there, I never got inured to the fact and I -- just that as I worked there, I had choices. There was a kettle, you know, in the office that I could put on and I could make myself a cup of tea. That I had money, that I could go and get something to eat, erm,

and that the people who were in the wards, you know, used to come up and use the kettle, which is quite right. Because they didn't -- they just didn't have access to privacy. Just things that we take for granted. And I just ...

I felt passionate about closing the hospital. It shouldn't exist for all the reasons -- simple reasons. I didn't want to live there, and if I didn't want to live there; why would I expect anyone else to?

It's not okay to sleep in a bed with a cabinet beside you and a curtain around you for a lifetime, to not feel safe, erm, yeah.

Q. Okay. At the end of paragraph 25, you talk about some wards being locked and in some there were people who were fairly heavily sedated, lying with no clothes on, people were wandering aimlessly around, and you mention the issue about the lack of personal space; was that in 1996 when you were working on the closure of the hospital or was that earlier?

A. No, that was in 1996 and until that ward was closed. There was a challenging behaviour ward, erm, and ... yeah, it was not -- it was the way that ward worked.

You would also see people, sometimes, in the grounds in a state of undress. You would see people sitting in the same bus shelter every day, because that's where

they went to go and get peace and quiet. There was a bus shelter, just at front of the hospital.

Erm, yeah. And there were wards where -- the locked wards where people would just have their ability to leave restricted and not necessarily under any legislation. It was just a ward. That ward was locked. You would get moved to that ward. You would then be in a locked ward.

Q. When you say that people were -- you do refer to this elsewhere in your statement -- that people were perhaps in a state of undress; was anybody trying to help or protect these people, or give them some privacy and dignity?

A. No, erm, it was their routine. There was one woman in particular and she moved. She moved out. And her stripping off of her clothes became a non-issue when she was able to wear bright clothes, her clothes.

Yeah, it was just a part of the way the ward was run. And I don't mean this to denigrate the staff in the wards. In institutions, things become normal for people that are really not normal, or shouldn't be normal, and you -- and some people can lose sight of that.

So, no, if you went into that ward and, say, the bus had gone out, because they would take people out on the

bus, anyone who was left often was sedated and then there would be a member of staff sitting and other people would be lying around.

Q. When you mention the staff, I think, again, you say in your statement that some of them had been there for a long time?

A. Yeah.

Q. Did that have an impact on sort of normalisation of the circumstances?

A. I think, yeah. I think undoubtedly. Institutions institutionalise those who work in them, as well as those who live in them.

Q. If we move on, please, to page 7 and paragraph 30, you say there that there was a 'punitive sometimes "arbitrary management" of "residents' behaviour"' and, in response, residents would find ways to exert some control in a system, and then there would be incidents of -- that you have referred to, which weren't unusual.

Can you explain a little bit more about what you mean about the 'punitive' and 'arbitrary' management of behaviour?

A. There weren't -- I'm just trying to think. It was so normal. So, if someone did something that a member of staff didn't like or want, there would just be a sanction of some sort that wasn't consistent across

the hospital. That's what I mean by 'arbitrary'. So: 'Well, you're not going out today', even if it wasn't a locked ward, 'You're not going out today'. Or having to stay in a room, having to sit in a corner, facing a corner. So I suppose that's what I mean by 'arbitrary'. You know, people would be restrained, physically removed, denied access to their dinner, you know. So, if you don't get dinner, you don't eat because that's when -- and, again, it was just -- I don't think anyone would have thought they were being necessarily abusive. It was just how it was.

So I'll give an example. There was a woman who used to come and visit me quite often. She was, sort of, quite a big character and she had ulcers. We found out after she moved. But, anyway, she had ulcers and she used to take milk, ask for milk to settle her stomach. On one occasion, she asked for milk in the ward that she lived in and she was told that there was no milk.

Then she saw the staff all sitting having their tea with milk on the table and -- she was learning disabled, but she wasn't stupid. So, you know, no milk, but there's milk. And she meted out her frustration about that on the ward manager's car and then she -- I didn't -- I didn't realise all of this had happened until -- I hadn't seen her for a couple of weeks and

then she came up and I found out that that's what had happened.

So I -- you know, it's not to advocate for vandalising somebody's car. But, for her, that arbitrary -- the control over something as routine as a glass of milk and no recourse to be able to challenge that, and then the detention for, you know, a couple of weeks on the -- because of that, because of what she did. All of that was arbitrary. It wasn't set down by any rules anywhere.

I suppose that's what I mean.

Q. At the bottom of the page, at paragraph 33, you say:

'One of the things that was really noticeable was when student nurses came, they would see things and they might raise complaints.'

Is that something that you observed?

A. Yes. Yes.

Q. Were their complaints taken seriously, do you know?

A. Er, yes. On some occasions, on the occasions that we were aware of, because it wouldn't come to us on the commissioning side; it would go to the trust. But we would hear of them and then some changes happening.

Q. Now, if we can move on, please, to page 9 and paragraph 41, you talk about healthcare, and you say:

'The odd thing about Lennox Castle being a hospital

was that people's health was not maintained.'

Then you go on to, at paragraph 43, for example, referring to drugs, including paraldehyde being a drug that people were taking and, over the page, at paragraph 44, you say, at the end of that paragraph:

'Anecdotally, once people's medication was reviewed in an holistic way after they had left hospital, it would often be changed.'

Can you tell us a little bit more about that?

I think, from your statement, you observed how drugs were administered in the hospital?

A. Yes. Again, it was very routine, literally, the drugs trolley. In terms of people's medication being reviewed and -- post-hospital departure, when they were in the community, we would be aware of people on large swathes of medication and then providers were supporting individuals to go to their GP. And then they would have their medication reviewed and there would be reductions in the medication over time. There were things that people -- just everybody was on, you know. Lactulose and Gaviscon. Everyone was constipated and needed -- and had medication for -- to settle their stomachs.

I mean, not everyone needed that. People were all ages and stages. So there was just some things that were almost distributed as routine. There were

medications -- and I mentioned the paraldehyde because that was, again, a rationale that was given for why this person couldn't move because they were on this particular medication in trying to work out if there was a way to -- I mean, I'm not medically trained, you know. I did just go and say: there must be a way if people with similar conditions are supported in the community.

We found out that that was a medication that actually had -- wasn't being used and there were alternatives. So, particularly for the cohort of people who were seen as challenging, medication -- erm, I would give examples from my own organisation and our support -- was reviewed because people's lives were changing. And you then work out what the medication is doing and whether it's needed anymore.

So there was just a greater attention on medication that's meant to do something positive, you know, and you try and get to the optimum level rather than sometimes it was just layered on, was the perception.

Q. Now, if we can move on, please, to page 12, and at the bottom of that page, at paragraph 58, you talk about record keeping. At the time that you were involved, you say:

'Notes were kept on the ward for each resident and then there were individual case files for each person

which would have historical information in them.'

Did you have access to some of those files?

A. Yes. They would usually be brought, so I very rarely went to the medical records building. But we could request them and get them. So that was where I got the information, reading through all of these historical case files, to ascertain those patterns of admission.

Q. If we go over the page, at paragraph 60, you say:

'Discipline and punishment were not recorded in notes because it wasn't necessarily reviewed in that way. But what you would see is the amount of PRN pro re nata medication ...'

So I think that's as required; is that right?

A. Yes.

Q. '... was administered, or you would see where somebody had been put into isolation. You might see that they had had their privileges withdrawn.'

You say it wasn't written as a punishment, but it was how their behaviour was managed. So you found that -- that was recorded in people's case files?

A. Yeah, yeah.

Q. In paragraph 61, you say:

'Written through case notes over and over again, you would see the words: "spontaneous aggression, no obvious triggers".'

And you say that was for people who were seen to be challenging. So, again, back to this phrase. And you say:

'Case notes were full of that phrase and that was used as a rationale and a justification for why people couldn't move out of hospital.'

A. Yes. So, in defining the person, people would -- clinicians would quantify the number of times someone had had to be restrained or had their PRN, or to support the reputation that was being assigned to that person, the level of difficulty. The reason why they should remain in the hospital.

Q. You say at paragraph 62:

'That tells you nothing about the person, other than that they have been repeatedly distressed.'

A. Yeah. Absolutely. I think it means that those who are supporting the person don't know how to help them live their good life. No one wants to be distressed, and if you're repeatedly distressed then it's either people don't know or don't care. And I -- I'm not sure I could answer that. But we know how to do better.

And to be so distressed that you're restrained, to be so distressed that you're medicated IM, intramuscularly or however, repeatedly, day in, day out, that responsibility doesn't sit with the person as

a person in distress.

Q. In the files that you looked at; was there any clear demarcation between when a person was there as a child and continuing into adulthood? Was there any clear dividing line?

A. No. And it was interesting in the discussion with -- when I was making my statement, because those societal norms didn't really apply in the same way. People would talk about when they move ward, rather than when a kind of -- a birthday/anniversary. People had very few, if any, remembrances or mementoes of significant life events that you or I would think would be normal, becoming a teenager, becoming -- you know, turning 18, 21. People left with, certainly in the early days, a black bag with clothes. No photos.

LADY SMITH: When you refer to a 'black bag', you mean the black bin bag --

A. Black bin bag.

LADY SMITH: -- with their probably very few possessions?

A. Very few possessions, and not always theirs. And we did make a formal complaint, sorry, just about people leaving with their possessions in a black bag.

MS INNES: So not only was there no clear demarcation in terms of the records and any difference between childhood and adulthood, the people themselves, when

reflecting back on their time in Lennox Castle, didn't -- weren't able to say, 'This happened before I was 18' or 'This happened after I was 18'.

A. It's very hard if you have no frame of reference.

Q. Okay. Now, if we move on again, please, to page 16, if we look at paragraphs 78 and 79, you are talking there about the use of restraint. You saw evidence of restraint being used in the files, in the case files, that you referred to; is that right?

A. Yes.

Q. And then you say, at paragraph 78, that it wasn't your understanding that there would be a review of the use of restraint:

'It was more the case that the attitude was that the person was becoming more difficult.'

Then you say at paragraph 79:

'We don't restrain people in C-Change, but we do hold a debrief.'

Then you talk about that. When you say, 'We don't restrain people but we do hold a debrief'; a debrief about what?

A. If someone's got upset or distressed. So there are often two reasons why -- well, there are more than two -- people will get -- be restrained in institutional settings because they're going to harm somebody else,

who lives -- a fellow resident or patient, they've harmed a member of staff, they're destroying property or harm to themselves.

And because we don't support people in congregate settings, we support people how they want to live, you know, unless they've chosen to live with somebody else, that rules out a number of these reasons why you might look to use restraint. If someone is living in their own home and they're destroying property, it's their stuff. So, obviously, we want to encourage people not to do that, but it just changes. It changes things fundamentally. Someone is less likely to break their own television than they are to have a protest and break somebody else's.

If you're not concerned about them harming a fellow patient, you can support someone differently. If someone is distressed, you can withdraw. You can do other things to help them regulate in a situation where you're not having to kind of manage all of these other things.

So we recognise that actually some of the worst things for people when they are dysregulated, when they're upset and distressed is -- one, don't say, 'Calm down, 'cause that rarely works for anybody and, two, laying hands on somebody. And particularly if you've

got a history of trauma and abuse, laying hands on somebody who is distressed can be the worst thing to do.

So we try really hard when someone gets upset to recognise that upset and think of ways, through knowing the person really well, to help them become less upset. It sounds very matter of fact and straightforward, but it's not how a lot of our institutional settings work.

And then the debrief is to work out: how did we get to here? And: how do we do better to not get to here again? I could give you examples of what that might be but ...

Q. Thank you.

If we move on down the page, still on page 16, at paragraph 81, you talk about the topic of abuse at Lennox Castle, and you say:

'Abuse; physical, emotional or sexual, wouldn't be reported, but it would come up in conversation.'

Why was it that it wasn't being reported but simply coming up in conversation?

A. You only report something if you know it's not normal, not accepted, it's not routine. So for -- it's a bit like the conversation about people lying around unclothed in a ward. That wouldn't even be written in those people's case notes, necessarily. If they hurt someone or hurt themselves in a way that, you know,

might need to be reported.

But people would talk about things that had happened to them, in a way, in a conversational style because it was just their living reality. It wasn't said to be -- to create an action. It was conversational, rather than: 'I'm telling you something for you to do something about this'.

So the person who told me that they had been unable to leave the ward after damaging the car didn't tell me that until I asked where they'd been. It wasn't, 'Oh, I've been detained in the ward for two weeks'; it was, you know, on the back of me saying, you know, 'I haven't seen you. Where have you been?', and then I was told.

LADY SMITH: How often would you be at the hospital when you were a commissioner?

A. It was my place of work.

LADY SMITH: Every day?

A. Yeah, pretty much every day, unless I was away doing something. I also was linked to the Royal Scottish National Hospital, Larbert, and so maybe once a week I would be over there. But, other than that, it was my place of work.

LADY SMITH: Hence you being able to ask somebody where they'd been?

A. Yeah, yeah.

LADY SMITH: Thank you.

MS INNES: If we go on over the page, to page 17 and paragraph 84, at the end of that paragraph, you say:

'With hindsight, I would reflect such matters should have been reported.'

I suppose this might have been in answer to a question along the lines of: if somebody said this to you; would you then report it onwards?

And you say there:

'With hindsight, I would reflect that such matters should have been reported, but at the time and place they were such a part of an institutional culture, it was remarkable in its awfulness, but it was routine. It was degradation, but it was just what happened.'

And I think that's probably consistent with what you've been saying about the normalisation of things that were not normal?

A. Yes. And through the process of giving the statement, erm, I reflected on my participation in not reporting each of these things that, now, when I look back, I think, you know: goodness, you know, I was seeing these ...

And so I think, in the same way as I was saying about the staff who worked in the institution, they weren't bad people. Some people did really bad things.

They were working in an environment that was an institution, with all of those aspects to it.

So it made me really think about my -- I was horrified. I thought I was doing the right thing. I was closing the hospital. It was: get people out as quickly as possible.

But you reflect back and think: oh, you know, should I have done more?

LADY SMITH: But tell me this, Sam: who would you have reported to?

A. Well, on the occasion that I did -- and it's in the statement -- on the occasion where I did report a particular incident -- and we would talk about it all the time and we would raise concerns. But -- so, when I did raise about a particular incident in relation to one individual, erm, I raised it with my line manager and then there was some action taken because it was reported to the trust and -- but, even then, the action that was taken was ... a sexual abuse had happened, a situation of sexual abuse had happened to this young man. The person who had perpetrated it -- first, there was a denial. Then there was -- that they moved the perpetrator to another ward and then, within weeks, because of the requirements in that ward, he was then moved back into the ward where the victim was living.

And I just remember, just being, you know -- just 'disheartened' sounds like it's just the wrong word. But just thinking, you know, the whole system just seemed to do this to people. And so the bit that I could do was to help him move and move as quickly as possible. And move well and into his own place, and to somewhere that would really work for him. And that's what I tried to do.

LADY SMITH: So you didn't see a way of making the hospital system work better, and your answer was: it's got to stop?

A. Yes.

LADY SMITH: Is that right?

A. Yeah. I think that was the only recourse I had. Having tried to report it and -- and there was a response, but it was just undone. It was ...

LADY SMITH: Thank you. Ms Innes.

MS INNES: Thank you, my Lady.

If we could move on, please, to page 19 and, at paragraph 93, we see you speaking about the barriers to abuse being reported by residents and, first of all, you say a lack of understanding that something was wrong.

The second, at paragraph 94, is the ability to communicate, and you talk about different communication methods. And I assume that, given your work, you are

familiar with communicating in different ways suited to the needs of the individual; would that be right?

A. Er, yes. So I fundamentally believe everybody can communicate, you know. People with profound and complex disabilities can communicate, if we listen carefully enough.

What we often fail to do is kind of listen to silences. We don't listen to people's bodily communications. I'm not sure we're very good at listening at all and we -- particularly for disabled people. Learning disabled people and autistic people, we spend a lot of time telling them who we want them to be, rather than listening to who they are.

So communication is a two-way thing when it works and, at the very least, we should respect people's way of communicating and try to do better and listen harder, and I'm not sure -- that was not really very much in evidence.

Q. At paragraph 95, you say:

'Another barrier to abuse being reported is that even if you do speak up, nobody hears you or does anything about it or if you do speak up and something is done about it, then it gets undone again. In speaking up, you have gone through all that you needed to do. You have voiced your concerns and yet things have just

gone back to how they were before. It is called "institutional drift".'

Can you explain that a bit further, please?

A. I suppose if I give the example of my feeling powerless in a system where I had kind of power and influence. I had an ability to raise an issue and felt that it really didn't make a lasting difference, then I think you -- it doesn't take a huge stretch of imagination to realise how someone who lives in that institution, who has, kind of, arbitrary rules and controls over things as mundane as whether you can get a glass of milk or something to drink, or leave the place that you're staying; how disempowered people would feel.

And oftentimes when people raised concerns about being hurt, they would just be: 'Oh, that's just what they do'. And that kind of wholesale dismissal of someone's voice just leaves you very vulnerable.

Q. Now, moving on in your statement at page 20, paragraph 100, you talk about the work that you do at C-Change, giving support to each person alongside multi-agency teams. You say:

'We feel that our specific contribution is to protect the person from the odd stuff that the system does to them. A judge once stated: "What is the point of making people safe if we make them miserable?".

Sometimes in our efforts to keep people safe, we actually make people miserable and miserable people will show you their upset and distress.'

In the context of the work that you did at Lennox Castle; can you explain that a bit further?

A. It goes back to the discussion about risk. If we take a view of risk that places the risk with the person: that they are a risky person, they do bad things, they do dangerous things, so therefore we have got to control and manage them; restraint, medical, chemical restraint. Restraint through restriction of movement. We -- that perception that individualises the risk actually fails to see the other risks in there; the risks of the person not leading a good life, of having opportunities to flourish, to ...

So, when we look at risk, I think we have to -- we have to recognise a lot of what we consider risk is about risk to organisations. We prioritise that rather than risk to individuals. So we will transfer the risk on to the person rather than try and share it more equitably.

So, if it involves a risk to an organisation of supporting somebody to do something they've not done before, say if someone wants to do something new and different, a lot of time our system says: 'Aha, but

what's the risk to the organisation if that goes wrong?' Rather than: 'What's the risk to the person of not having that opportunity to make a mistake, possibly, to not do it perfectly?'.

And I think that's what that wise judge was trying to get at. We don't view risk in a way that balances it in -- as well as it should be. In part, because we have control and power over people and we get to define it rather than individuals themselves.

Q. If we go on over the page, at paragraph 105, that, I think, continues the idea that you have been speaking about:

'It's all about understanding that each individual has bespoke needs, rather than trying to fit a standard response around them.'

It's moving on, perhaps, to a slightly different area:

'It's about designing support around what each person needs for them, their home, to the people who work with them and matching the people who work with them.'

So that's looking at the staff, if you like, or people that support them, being the right people for the individual.

A. Absolutely. And for some reason, it seems like

a remarkable thing. But, actually, the rest of us get to choose who's involved in our lives. And if you have people who are in your most private space, in your home, helping you with your day-to-day activities, we would choose. It's not remarkable, except in our social care system. And particularly when we look at institutional care, it is remarkable.

Q. If we move on to page 22, paragraph 107, you say there:

'I often say you do not want to be judged on your worst day, yet we carry a person's history around with them and we design their whole lives around their worst day.'

A. Absolutely. And particularly for this cohort of people. That's the spontaneous aggression, no obvious triggers. Look how many times this person has been distressed and upset, and this is still now -- this is how we're defining people and -- yeah. So when we ...

We shouldn't -- we shouldn't ignore the days and the experiences of distress that people have had. But rather than looking at look at how awful this person is, if we said: 'Look how awful their life has been that they have spent so much time in distress. We can do better', but that -- it isn't how much of what we do works.

So, if someone's done something at some point -- you

often have to -- it's like an archaeological dig to try and get to the actual reality of what someone's done. What was it?

Even then, when you get to that signature thing, what you're getting is one person's testimony and not, often, the person who is the subject of it. Their voice is very rarely there. So: 'before I stuck that person's head in the sink', or whatever it was; what was going on?

And if we just thought: 'Well, wait, what for us would have us do that?'

It's rarely, very, very rarely it's a spontaneous act. There are other things. There might have been lead-ups over days, weeks, and so rarely does that get written up.

So we have a signature event that becomes a stone around people's neck and a reason why all of these other things they might want to do can't happen because that thing happened. And we don't do that archaeological digging back to, and then try and work out what might have been, nearly as often as we should. And so people -- it's almost like a papier-mache reputation. You know, they grow bigger on this seed of this thing and it's just so often, in my experience and in my work, not the case. People are more than that and they have

the potential to be better than that.

Q. Now, if we can move on, please, in your statement to page 28, where you are referring to the Lennox Castle Stories project that we saw earlier in the week. You talk about the work that was done in relation to that and some of the matters that we have already covered in your evidence in relation to a lack of demarcation, a lack of rituals and reinforcers of a pattern, you say.

At paragraph 142, you say:

'Some people lost their names in the hospital on occasion.'

Did you see that in the records?

A. Yeah, because people would be referred to as one name and there might have been like four [redacted] in a ward and suddenly, you know, that's complicated or that just adds to confusion so someone will become something else and then you see through the records, you know, and you track it back and --

Q. Their name has changed?

A. Yeah, and the person's name has changed. There was a guy called [redacted], and the reason he was [redacted] was because, I think, at one point there had been a large number of [redacted].

Q. Okay. If we go on to page 29, you talk about lessons to be learned. Again, we have looked at some of these

aspects already but, at paragraph 145, you say:

'One of the issues historically is the idea of perpetual children; that people with learning disabilities are infantilised.'

And can you explain a little bit about that and how that impacts on people?

A. Well, you'll be aware of the -- we still often use infantilising behaviour -- people with learning disabilities. And the idea of IQ, I think, also plays into that. People say, 'This person's got the intelligence of a 6-year-old', which is singularly unhelpful because they're embodied in a 23-year-old's body and, you know, what 6-year-old are you talking about when you say that? It doesn't really help you understand that person any better. Knowing how that person experiences the world, what communication helps them, is a far more -- yeah, just far more helpful way of understanding.

And this idea of treating people as children also makes people extremely vulnerable. And I referred to Dave Hingsburger's work around the ethics of touch because overfamiliarising, you know, touching people in a way without respect, without asking. And I mean that routinely, when you are supporting someone with their personal care or to assist in dressing, each and every

time reinforcing bodily autonomy is vital for helping people understand their boundaries and other people's, and what is and isn't okay.

Q. I'm going to ask you to look at one other document, please. INQ-0000000817. This is a news report from 7 January 2022, 'The shameful legacy of the Lennox Castle Hospital', and I think you contributed to this report.

If we look at page 5, and if we scroll down to the bottom of the page, you are being asked about -- it says:

'Dr Smith says that the large institutions may have closed, but she feels there is still much to learn about how people with learning difficulties are supported.'

And:

'We need to do better [you say]. All the potential lessons that could have been learned from the process of decommissioning the institutions haven't really been taken on board as well as they could.'

And then does the quote go on to the next page:

'We could do so much better than we are.'

Now, I'm sure you have mentioned some of the things we could do better in the course of your evidence so far. But I just wanted to check if there were other things that you haven't covered in your evidence that

answer this question, where you say that not all of the lessons have been learned and there are other things that we could learn from past?

A. We're still institutionalising children and we're still doing it at the same markers. So adolescence is a time when learning disabled and autistic children are ending up in institutional settings. We're still restraining children in schools and in institutions.

We're still requiring children to fit in to places that hurt and harm them, into environments that they find overwhelming and then, when they get distressed, we say, it's them and require them to fit, when fitting is painful. Fitting is beyond them. Fitting in, I mean, is beyond them.

We're letting down families, because when we speak with families, they talk about fighting, fighting the system. Fighting to get the help they need, until they get to breaking point and they have no other choice than either their child is taken away or that they say they can't cope any more. And that's the same reasons that children ended up in Lennox Castle. And we do know how to do better, but we're not.

It's unacceptable because then we have all the harm that's done to families and to those individuals, and then that makes supporting those people through their

life that bit more -- it can be more expensive because we've done the harm and then we have to help people develop their trust and faith.

And so, yeah, that's what I was referring to.

MS INNES: Thank you very much. I've got no more questions for you.

LADY SMITH: Sam, I'm so grateful to you for coming along this morning and talking to us about memories that I'm sure are really difficult to go back to. But it's been such a valuable contribution to the work that we're doing here.

A. Good.

LADY SMITH: Thank you.

I hope the rest of your day is more restful than we've given you for the start.

A. Thank you.

(The witness withdrew)

LADY SMITH: We'll take the morning break now and the next witness should be ready for after the break; is that right?

MS INNES: That's correct and Ms McMillan will lead that witness.

LADY SMITH: Thank you.

(11.31 am)

(A short break)

(11.46 am)

LADY SMITH: Welcome back, everybody. Now, Ms McMillan, next witness.

MS MCMILLAN: Yes, thank you, my Lady. The next witness is Rhona Morrison, my Lady. She is a retired psychiatrist who spent time professionally working at Lennox Castle, but also has some personal involvement, as her sister was a patient there.

LADY SMITH: Thank you very much.

Rhona Morrison (affirmed)

LADY SMITH: Thank you so much for coming along today to help us with evidence you are able to give about matters we're particularly interested in, in this part of our case study hearings. Thank you also for the detailed statement that you provided in advance of today. It's been so helpful to have that. But I'm sure it was hard work for you engaging and providing it.

First question I have for you is: how would you like me to address you? I'm very happy to use your second name, your professional title, your first name, whatever you are comfortable with?

A. The first name's fine.

LADY SMITH: Okay, thank you, Rhona.

As we go along, if you have got any questions, please don't hesitate to ask. If you want a break at

any time, just say. Obviously, I'll stop for the lunch break at 1.00 as we normally do and we may well have finished your evidence by then. But, if not, you can look forward to that giving you a breather at that point.

If you're ready, I'll hand over to Ms McMillan and she'll take it from there; is that okay?

A. Okay. Thank you.

LADY SMITH: Thank you very much.

Questions by Ms McMillan

MS MCMILLAN: Thank you, my Lady.

Good morning, Rhona. Thank you for attending this morning. I understand that you provided a comprehensive witness statement to the Inquiry, the reference is WIT-1-000001523. And I think you have a copy of that in front of you?

A. I do.

Q. Hopefully you can see it on the screen as well?

A. I can.

Q. Turning to the very last page of that statement, which is page 45, we can see at paragraph 162, there is a declaration there indicating:

'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.'

Do you see that?

A. That's correct.

Q. We note that that was dated and signed by you on 13 November 2024?

A. That's correct.

Q. I want to take you back to the first page of your statement, please. At paragraph 3, we note that you tell us about your qualification. I understand from that, that you finished your degree in medicine in 1985?

A. I did.

Q. Thereafter, did you specialise in psychiatric medicine?

A. I did.

Q. Where was your first position of employment after you qualified?

A. After I qualified as a doctor -- do you mean as a doctor?

Q. Yes.

A. As a doctor, I worked at the Southern General Hospital for one year and then went on to Dykebar Hospital in Paisley to begin my psychiatric training.

Q. And during your time training in psychiatric medicine; what sort of areas -- or where did you work?

A. So the training scheme was based at Dykebar so, every six months, we changed specialism. So general adult

psychiatry, child psychiatry, addiction psychiatry, liaison psychiatry, old age psychiatry, et cetera, et cetera.

So we were based around about the Paisley area. There were some at the Royal Alexandra Hospital and other outlying areas. The child psychiatry was in a different building from Dykebar Hospital. But most of the training was in that area.

Q. So you had a general training in psychiatric medicine and then; did you go on to specialise in a particular area of psychiatry?

A. Yes. You have to sit the membership of the Royal College of Psychiatrists Part I and, after passing that, you are able to apply for a specialism in psychiatry. And I applied for forensic psychiatry and was accepted to train there and went to the Douglas Inch Centre, in Glasgow.

Q. In your role as a forensic psychiatrist; what did that involve?

A. Again, that was -- normally that would be a three-year training in the specialism, I actually did six years. I was fortunate that there weren't any jobs that I particularly fancied, so I got a very comprehensive training. Every six months we would change again. But, within forensics -- so I did working in secure schools.

I worked at the state hospital consistently throughout that. Intensive care psychiatry and general adult hospitals. I did addictions. I did sexual abuse clinics. I worked at the Mental Welfare Commission. I worked in male prisons, female prisons, young offender establishments, secure schools, addiction services. Yeah, quite a lot. Various -- and learning disability, sorry, as well, at Lennox Castle, that was one of the placements I requested because that's my special interest.

Q. So you indicated there that you requested a position at Lennox Castle?

A. Yes. My original -- when I was at Dykebar doing general psychiatry, my original intention was to train as a learning disability psychiatrist. There were only two training posts in Scotland at the time and they had just been taken before I passed my membership and so that line was not open to me, which is why I ended up doing forensic.

But I had expressed an interest in learning disability forensic, which wasn't available at all at that point and they were trying to create a post for me. So I was trying to get some experience in forensic learning disability at Lennox Castle in the hope that they would be able to create a new consultant post.

They didn't in the time available and so I didn't do that eventually. But that was why I had asked for additional input.

As a medical student, I had gone abroad to look at learning disability services in New Zealand as well, because that had been my initial intended area of expertise.

Q. Was there any particular reason why that was your intended area of expertise?

A. Yes. I'm the youngest of three daughters and my middle sister was born with learning difficulty, physical disabilities and sensory impairment. In old money, my parents were told that she was deaf, dumb and blind and that she required 24-hour care. So she was an inpatient initially in Waverley Park Hospital in Kirkintilloch and then in Lennox Castle Hospital from sort of teenage age. I don't know exactly her age. And so I was a regular visitor every week, until my sister sadly passed away at age 23.

And I liked working with that population and thought a career working in learning disability would be rewarding. That was my original intention.

LADY SMITH: Was she older or younger than you?

A. She was older. I was the youngest of three. She was about two-and-a-half years older.

LADY SMITH: Thank you.

MS MCMILLAN: We will come to talk about your visits to your sister, which I know you discuss in your statement. But, before we do that, you had indicated that you had experience of dealing with those with learning disabilities in the course of your training.

Looking at page 6 of your statement, in particular at paragraph 20, we can see that you also had some involvement with the Royal National Hospital at Larbert; are you able to tell us a bit more about that, please?

A. Yes. It was a link between the Royal Scottish National Hospital at Larbert, Merchiston Hospital in Paisley, which was also a learning disability hospital, because I had decided to do some research into blood pressure in Down's Syndrome. And I was comparing populations who were institutionalised in hospital compared with those who were living at home and attending community resources, to look at the impact of different environments on stress levels and blood pressure.

And so I was visiting the hospital to do blood pressure recordings of -- all these areas, adult training centres, as they were then, in the community. So I was visiting regularly to do blood pressure recordings and then I actually followed up the same

individuals ten years later. I went back and did them again to look at the passage of time on impact.

So that, I guess, demonstrates my early interest in learning disability, even as a medical student.

Q. In paragraph 21 of your statement, you indicated that some of your investigation involved those that had been diagnosed with Down's Syndrome?

A. Yes.

Q. We can see that you say that there should be more stress in the community compared with an institution; what did you mean by that?

A. Erm, perhaps I wasn't clear. I guess, in an institutional setting, the environment's quite protected. You're not exposed so much to people shouting out jibes in the street or to -- having to cope with paying for things in shops and getting on and off buses, and finding your way around, just the general stresses of daily living.

It's generally accepted in an institutional setting, people with any diagnosis are perhaps less stressed because it's more protected, things are done for you. And so I was trying to see whether the environment was having an impact on blood pressure or not.

Q. What was your ultimate conclusion to that?

A. The findings were quite unusual, in that people with

mental health problems of any kind, like schizophrenia or people with a learning disability, not Down's Syndrome specifically, over time your blood pressure rises with age. People in an institution, it doesn't rise at the same rate, but it still rises.

And people with Down's Syndrome, I discovered it doesn't rise over time at all, regardless of environment. So there's something to do with the syndrome itself that's protecting them.

Q. Just moving on to page 7 of your statement, I think on paragraph 22, at the end of that, you indicated that you went on to the ward, you saw people and went back out again. But nothing stands out in your memory as being particularly good or particularly bad about the Royal National Hospital?

A. No. I have a very, very patchy memory of that. I just remember the interactions with the patients I was dealing with and trying to engage with them, and not be the person -- I didn't wear a white coat. But, you know, there's a doctor coming in to do this painful thing in their arm. Trying to just be generally chatty and find out what they've been doing this week.

And so I was more about trying to engage the patients than really observing the environment.

Q. Just picking up on what you said there, you mentioned

that you didn't wear a white coat; is there something specific about that?

A. Yes. There's a thing called the white coat effect which can affect blood pressure. If -- people's blood pressure will go up if you're wearing a white coat. It's the doctor effect. So not wearing a white coat was helpful.

Q. And the patients that you saw in the Royal National Hospital; did they tend to be adults that were diagnosed with Down's Syndrome?

A. Erm, I can't remember exactly. But I think my research focused on the population between 60 and 65. And, at the time, that was quite good because people with Down's Syndrome in particular had cardiac difficulties and often hadn't been operated on in the past and tended to die early, so it was quite unusual to have people as old as that in my study.

So I don't think we actually excluded anyone; I think it was just by chance. But I don't think there was anyone under 16, from recollection.

Q. Thank you. Moving to page 11 of your statement, and in particular paragraph 37, at this point I think you've been asked about your observations during the course of your role as a psychiatrist; now, is there anything during your observations with people with learning

disabilities that you can tell us about?

A. I think my general impression in institutional settings -- and that's where I saw most of them at that stage -- was that some behaviours were tolerated and not addressed, which would not be tolerated in a community setting. And I found that quite hard to take, because if you don't tell people their behaviour is inappropriate and teach them an alternative or show that there's a consequence for a behaviour, then the behaviour is likely to continue. And I felt that was really negative for the patients. If they were trying to rehabilitate and get them back into the community, they might be masturbating in the corner of the cafe in the hospital, and, 'That's just [redacted]', was the sort of thing that people would say. And I would say, 'Well, that's not acceptable. We need to help [redacted] know that that's not appropriate in that environment'. There are places where you can do that in private, in your own room. It's not that it's wrong; it's just the education wasn't there.

Q. And what was the attitude to education at that particular point?

A. I didn't get much of a -- I mean, I was only in passing, so it's not a fair judgement, really. But I didn't get the impression there was a lot of education for staff,

never mind for patients about -- particularly about sexual matters. I think there was that sense of feeling that people should be protected. You know, they've got problems, they've got learning difficulties, so somehow they wouldn't have hormones or sexual drives that needed to be addressed and they needed to know what was appropriate and what wasn't appropriate.

So I felt quite strongly all my career that, you know, education is key.

Q. And when you talk about some of your observations and in particular, from what you've been saying there; were any of these observations at Lennox Castle at all or was it just collectively your observations of what you remember?

A. I think it's fairly collective. There's the sense that people don't -- or didn't back then, and it's a long time ago now -- didn't really address behaviour and the appropriateness of it.

Q. Thank you. Now, turning to page 13 of your statement, part of your training, we can see at paragraph 42 you also worked with deaf patients.

And looking at paragraph 43, we can see that there were deaf patients that were -- well, those that were involved with the deaf patients were learning Makaton and then there was BSL, see that there; was there

a particular difficulty in communicating with deaf patients?

A. I had very limited contact with deaf patients. It was literally if they were referred to me, so we are talking less than five, I think, in my career.

And so there's a difficulty with learning difficulty generally in that you have to be careful about the language you use. It needs to be simple. You need to not be leading them, very open questions, simple language, and make sure they understand the question.

So, when you are dealing with someone with learning difficulties who also was deaf, you were having to use, like you say, Makaton or BSL and you'd have an interpreter there. When I was doing it for the court, it was with a BSL interpreter and I wasn't sure how much the patient understood the sign language. So communication was incredibly difficult.

And then finding a language to use, particularly when it was a sexual offence. I had to find language that they would understand.

So, yes, it was very difficult.

Q. And I understand from your statement that those individuals that did have these difficulties tended to be adults; would that be what you recall?

A. In terms of the sexual --

Q. Or the deaf patients that you encountered?
A. Oh, the deaf patients that I encountered were adults, yes.
Q. As you indicated, you have spent a lot of time at other places, such as St Mary's. But, today, I would like to focus on Lennox Castle in particular.
A. Of course.
Q. Can I take you, please, to page 29 of your statement, and we'll see from paragraph 94 that we're talking here about your sister. You had indicated earlier that the phrase then used was 'deaf, dumb and blind' and we can see that in that paragraph.

How was communication with your sister or your communication with your sister?
A. My sister, in her whole life, never uttered a word. She would goo and ga and that was all. And laugh. You couldn't -- I could never ask her how she was or what she felt about anything. She just lay -- she couldn't sit up. She lay in a cot and would smile.
Q. And we can see that on page 30 of your statement, at paragraph 97, that your sister was moved to Lennox Castle perhaps around the time of adolescence and she remained there until she died, at the age of 23.

You have indicated in that paragraph that one of -- your sister lay in the same position for 23 years and

never once had a bed sore, and said that that's absolutely remarkable; why was that remarkable?

A. Well, you'll know from anyone who -- an elderly person, for example, who can't get up and about, all the pressure goes through certain points, where your weight is pushing into the bed or seat.

My sister, because of the contracture she had, you couldn't even move her onto one side or the other, or sit her up. She lay flat in a sort of foetal position, if you like, on one side, without moving. She couldn't actually move herself at all. And so you would expect, very quickly, that there would be pressure sores and never, not once, did she have a pressure sore, and that's really, really good nursing care.

Q. And scrolling down at paragraph 99, I think you indicated that because of the care required towards your sister, she was in the hospital within Lennox Castle Hospital and it was a bit different from the rest of the hospital in terms of the level in care.

A. Yes.

Q. Are you able to tell us more information about that?

A. So I think the people who need particular nursing care, as opposed to care -- you know, help with getting dressed or feeding, if they needed actual nursing procedures, like skin care, like my sister, or whatever,

then the ones who needed more input were in the hospital within the hospital. And there I think -- I don't know for definite but I think the proportion of trained nurses was higher and, probably, the staff-to-patient ratio was probably different as well. But I don't know the details of that. But that's my assumption.

So the care, I think, was necessarily a bit different there. But I never worked there because I wasn't allowed because of the conflict of interest.

Q. And when you went to visit your sister; what sort of ward do you remember her being in?

A. She was always in a day room when we were there and she was in an adult pram. And so there would be several other patients around, some wandering around and some in prams.

Q. So when you say 'adult pram'; can you just describe that in a bit more detail?

A. It was maybe a metre-and-a-half long, made of wicker, but it had big wheels and a handle. So it was like a bed on wheels, so that they could take her about, because she couldn't sit up. She couldn't sit in a wheelchair or anything like that.

Q. So for the entirety of your visit -- was your sister always in the day room when you went to see her?

A. She was always in the day room, I think. We could lift

her out and put her on our knee and, you know, give her a bit of physical stimulation. But, other than that, that was where we were.

Q. Were you aware, during the time when you were visiting your sister, if there were any more children present in the hospital area?

A. I don't recall that. I don't think so, but I don't recall.

Q. Now, turning to the next page of your statement, at paragraph 100, you indicate in that particular paragraph that your sister always had her own clothes, that you would take them home and wash them. Was that different from other parts of the hospital?

A. I obviously can only talk to the parts of the hospital that I visited. But I was, as you said earlier, a nursing assistant during the summer holidays at university and I was working in male and female wards. And particularly the male wards, my recollection was of a huge pile of clothes in the middle of a Nightingale ward in the morning. Men sitting naked on beds with no dividers and a pile of clothes. And they weren't named. You had to pick up a pair of trousers that you thought would fit, and if there was a broken zip, you had to find a long jumper. And if you got two brown socks, then you were lucky. They weren't ever paired.

So it was really not personalised care at all. And that stuck with me quite dramatically throughout my career, how inappropriate that was.

Q. And this was almost contrary to the care that your sister --

A. Yes, it was very different. I mean, if you asked our family about my sister's care, her skin was cleaned. And she was incontinent, but they always changed her, and her clothes were clean, you know, and she got music therapy when -- she was recorded as being deaf, but she could hear sort of sounds, I think. She would respond if you made a funny noise in her ear, she would giggle. So they had picked up on that and she got music therapy.

So the care she got seemed quite stark in contrast to what I was witnessing in there, the bigger male wards.

Q. Moving on to your time as a nursing assistant, you indicate, I think, at paragraph 102, that your first recollections of the ward that you worked in as a student were very different from the ward that your sister was on.

So what sort of wards were you working on?

A. I worked mostly in the male side of the hospital and they were big Nightingale wards, just a big rectangular room with beds up either side and not much privacy. And

then during the day, they would all be moved through into a big, huge day area that had a dining room and hatch to the side, as I remember it.

Erm, so they were quite different from what my sister was in.

Q. And the wards that you were working on; did they tend to be quite full?

A. Yes, I remember them being very busy.

The female wards, I don't remember them being as big, but I might be misremembering that.

Q. And, as you were telling us about earlier, part of your role was, really, to help dress some of the males in the ward. Were there any processes for that or did you receive any training?

A. No, my induction was I was given a nursing assistant's tunic and taken into the ward and told to dress the men. I'd never seen a naked man before and there were a whole ward full of them, sitting on beds.

Q. When you were carrying this out; was there anyone with you?

A. There were other staff doing the same thing.

Q. And you indicated that you were given no training, no induction; were there staff with experience round about that you could turn to, if you required assistance?

A. There were staff in the wards. I think my general sense

was that they were understaffed.

Again, that's purely a recollection. I don't know what the right staffing ratio would be. But there was a lot of patients who required support in dressing and bathing and feeding, and just in terms of giving any quality of care. You know, in terms of stimulation during the day, if you had more staff, you would have been able to do more and just sort of watch that everyone was safe.

Q. You mentioned the dignity and privacy of the male patients; can you tell us a bit more about that?

A. So there was the incident, obviously, when they were getting dressed, so that was -- there was no privacy. And then my other main memory was when I was asked to bath the men and there was a room with two baths in it, erm, and two lines of naked men standing waiting to be bathed and having to bath them. And there was no dignity at all and that really felt -- I mean, I was young. I was still at school at the time, early on, and in the early days at university. But it didn't feel right and the more I became involved in the NHS when I was doing my training, it was very clearly not right.

Q. You have spoken about clothing and the bathing. What about meal times and giving out food, et cetera? Did you have any involvement in that?

A. Yes. Again, the two things that stick in my mind are that there was no -- there was lack of choice. The teapot was a giant teapot with tea bags, milk and sugar, everything put in the teapot and everyone got the same. You didn't get a choice.

And when you were feeding patients -- some could obviously feed themselves, but there were people like my sister, although I wasn't involved with her, people who were in the adult prams who couldn't sit up. Often they had epilepsy as well and they were sort of lying in a pram and you were having to feed them and they might have a seizure during you trying to feed them and there were very few staff around and that felt unsafe. And I felt quite vulnerable as a member of staff.

Q. I think you touch on that at paragraph 107 of your statement, on page 32, about some of the patients having seizures when you were feeding them?

A. Yes.

Q. How did you cope with that?

A. Well, obviously you would stop feeding them and try and make sure they didn't choke and try and get a member of staff. But the staffing was quite limited at times.

Occasionally, you were in a large ward with yourself and the charge nurse and that was all that was on at that point. So it was quite difficult.

Q. And the males that you were attending to; were you aware if they had any -- did they have learning difficulties? Did they have diagnosed medical conditions, as far as you're aware?

A. My understanding is that all the patients in Lennox Castle at that time -- it was different in previous times. But I think all of them would have had a diagnosis of learning difficulty of some kind.

But, again, being a nursing assistant for the summer, I had no knowledge of any other physical illnesses that they might have. You would notice if someone was starting to have a seizure and someone would say: 'You need to be careful, they have seizures'.

But I didn't really have any knowledge of any other pre-existing conditions. Other than one gentleman who had extremely severe psoriasis, who needed a particular regime of multiple creams and bathing and whatnot, and he had incredibly good care. It was very diligently, we were told what to do and that was adhered to.

Q. Does that stand out to you as an exception?

A. Yes. Uh-huh.

Q. Looking at paragraph 108, on page 32, you say that Lennox Castle was:

'A total institution, which is not healthy. There was a lack of dignity and personalised care. The staff

were employed from the local community. They were all related to each other. If you said something, you had to watch because other people would be there. It was difficult.'

Can you expand on that at all for us?

A. I think it's not the only place I've ever witnessed that sort of total institution -- you know, back in years gone by, there was a lot of local employment. People, neighbours, friends, relatives, partners, there was a lot of people employed from the local community. So anything that was said, there was a sense that it was going to get back to whoever you were talking about or whatever. So I think that's not a healthy culture for people if there is any -- I didn't even know the term 'whistleblowing' then. But, if you wanted to report something, it didn't feel a safe place to do it because you didn't know where the information was going to end up or if people would go against you if you did raise something. So I think that's just a general thing that's acknowledged in large institutions.

And there was a sense that if the doctors were going round the wards, you know, on their ward rounds, there was phone calls. I would hear them phoning: 'Doctor's on his way', and people would be tidying and doing stuff. So there was a sense that, you know, they were

presenting what they wanted to be seen.

So, yeah, and again, I don't think that's healthy.

Q. And when you talk about that; did you feel comfortable that if you had seen something, you could report it at all?

A. No. No one threatened me or said anything would happen. It just didn't feel -- the culture was such that it didn't feel right to report things. And I was young then.

Q. And if you had seen something that caused you particular concern; who would you have reported it to?

A. The only person -- there was no supervision, so the only person would have been the charge nurse on the ward, I guess, really, and that didn't feel particularly safe.

Q. I think, turning to paragraph 111, on page 33, in that particular paragraph you tell us what you were saying in your evidence:

'The chief doctor was a physician superintendent. The culture was such that if the doctor was doing the rounds, staff would phone ahead to the other wards and say that the doctor was on their way. There was a sort of warning system amongst the staff, which culturally doesn't sit well with me.'

What did you mean by 'culturally doesn't sit well' with you?

A. Well, obviously I went on to become a doctor and, ultimately, I was in charge of the other doctors in my service, and the one thing you want is for people to be open and to be able to report if there's something of concern and to learn from things. And, you know, back then, it didn't feel an open place that you could discuss any concerns. So the culture didn't feel right.

And looking back, it feels less right, if you know what I mean? I'm giving evidence now, having seen how it should be, and feeling -- recognising even more that it was not a healthy culture.

Q. Even at the time when you were working there as a nursing assistant and, I suppose, with limited experience of how things operated; did you feel like there was a culture of secrecy?

A. I don't know that I would use such a strong term as 'secrecy'. It just felt that everyone was kind of keeping tabs on each other and -- that's not even the right wording. How can I put it?

Q. Perhaps, if I may ask you a different way: did you feel like there wasn't as open reporting or as open observations of things as they actually were before the doctors went in?

A. Yes, I don't think -- I think that's probably -- it summarises it better, yes.

Q. You had mentioned about the staff sort of knowing each other; was your understanding from your experience that it was local people employed in the local hospital?
A. That was my understanding. There were certainly lots of relationships across all the wards. Clearly, I don't know about the full staff group. My own family, some of my own family lived in Lennoxtown and they knew a lot of the staff. So there was a sort of personal knowledge as well as just an observation.
Q. Now, moving to page 34 of your statement, where you talk about your time then returning to Lennox Castle as a senior registrar; had your impressions changed from what you had initially seen as a nursing assistant?
A. I was very much popping in for a short space of time and away. I wasn't working in the unit and I didn't have responsibility for actual individual patient care. It was more of a learning experience for me, to observe the importance of interagency working, particularly with this group of patients.

So I would go to a multi-disciplinary team meeting, so I didn't really get much of a sense of the overall working of the hospitals and the culture.
Q. I think you go on to say, at paragraphs 115 and then 116, that at one point you do remember feeling slightly frustrated because you didn't always think that they

were as proactive as what they might have been. I think you're talking about staff there, but what did you mean by that?

A. I guess my whole -- in my career, I've been very much an advocate of holistic care; not just about getting a diagnosis and treating someone, you know, for that diagnosis with medication, for example, but actually the quality of care. Again, that stems back to my sister. The holistic care about the quality of life. So whether it's -- their social activities, their relationships, their housing, their diet. The whole thing that makes quality of life. So I was obviously: 'But what about, and what if', and I was kind of -- I felt I was pulled back a little bit in terms of: 'Well, we're dealing with the main things just now'.

And actually, the main things to me seemed the whole aspect of your quality of care and I thought we should have been addressing perhaps more -- nothing specific. I just remember I was probably a bit more proactive than perhaps the staff that were there at that moment in time.

Q. Taking from that; did you feel that your views of looking at that holistic approach to care were perhaps not what was done within Lennox Castle at that point?

A. No, I think they were multi-disciplinary, multi-agency,

trying do things. I probably was just pushing a bit further and I tended to do that my whole career. So maybe it's just a feature of me, rather than a cultural thing. But, also, I think -- I mean, I was fortunate. I had visited other countries and -- looking at services, so I was aware of other projects that were happening, which were perhaps at the time, way back then, a bit further on than us. So trying to just make people think about other options, I guess.

Q. At paragraph 117 on that page, I think you indicated that you weren't party to the admission of patients at Lennox Castle. But there were some historical cases where people had maybe had an illegitimate child many years before they had ended up at Lennox Castle and never left.

In that particular point; are you talking about the mother or the child, or both, from what you remember?

A. This was all anecdotal evidence, you know, people would tell you these things when you were working in the ward. So I can only give you that information on that basis. But my understanding was it was someone who had had an illegitimate child as a young girl and they'd been admitted there, to the hospital. They put the mother -- the patient who had had the baby, they were admitted and then never left the hospital.

And I don't know if they had a diagnosis of learning difficulties or not. I know the hospital had a wider remit in the past, so I'm not entirely sure.

Q. You go on, on that same paragraph, as it turns on to page 35, and we can see that you say:

'I think of lot of people went into Lennox Castle because they had a learning disability and not because something specific happened. I think that was the advice that families were given.'

Can you tell us more about what your understanding was of the advice that families were given?

A. This is purely my understanding. It's not based on any training I've had or anything.

Just from my own family's personal experience, my sister, as I said, she couldn't sit up. She wasn't behaviourally disturbed, she didn't communicate. She just lay in a bed and needed 24-hour care and they were advised at that time she would need to be in 24-hour care, so that was what happened.

Nowadays, I think the advice would be very different. If families can manage a relative at home, they'll be encouraged to do so and they will have services or support coming in as necessary. So I think the guidance has changed quite dramatically.

But I know in adult mental health, which is -- and

I know that's not what you're dealing with here -- but similar sort of guidance in the past. If someone had a severe and enduring mental illness, they were often advised that their relative could come into what was then a sort of long-stay hospital, institution, and they would be cared for for life. And people, relatives have quoted that to me when we've tried to rehabilitate someone into the community years later: 'We were told they'd be here for life and they'd be safe'.

And I think the message might have been similar in Lennox Castle. That people were -- it's a safe place for them to have quality of life and be cared for. And then, obviously, the thinking changed about normalisation and the institutionalisation and rehabilitation. So I think -- I don't know if that answers your question.

Q. I think you then touch on that as well, at paragraph 119 of your statement, that there was that attitude towards institutionalisation. But then, towards the bottom of that paragraph, you say:

'When thinking changed, some families who had been promised long-term care were suddenly told that their relative was getting out at the age of 65. It was horrifying for families because they thought that their relatives were safe in care.'

What did you mean by that?

A. Going back to what I said a moment ago, the relatives reported that they'd been told this was a home for life and they would be safe and they would -- and there used to be maybe a farm or a garden, or something in the hospital where they would get a little job and they would be cared for in terms of they had somewhere to stay and they would be fed, et cetera, but it was almost a kind of enclosed community.

And the families were horrified at the thought that they thought their son/daughter, brother, whatever, was safe and suddenly they were going out into, in their terms, the big, bad world, where they might be vulnerable to abuse or exploitation and might not have the skill sets required.

So I think that's what I was trying to say.

Q. So it was an understanding that the patients would be safer within that environment than they would have been outwith?

A. Yes. Yes.

Q. Moving on in your statement, just to that bottom paragraph, paragraph 120, you had told us that your sister had the benefit of music therapy. Were you aware of any other sort of provisions, or input like that, that other patients received?

A. I don't have a recollection of it. But, again, my contact was limited to a few months each summer during my university. So it wouldn't be fair to say there wasn't any. I just wasn't aware of it.

Q. Other than the music therapy that your sister received; was there anything else that she received during your time?

A. Not that I'm aware of in terms of a specific therapy.

Q. Moving on to paragraph 121, on page 36 of your statement, I think, at these two paragraphs, you talk about the hospital disco; can you tell us a bit more about that?

A. I was just made aware that there was a hospital disco. Some of the patients that could talk would talk about it as something, you know, different that they could go to and they enjoyed it. I thought: I would love to see patients having fun.

And so I asked if I could take some of the patients from the ward to the disco, and it was -- it was agreed, but I had to bath the men first. While the other staff didn't do any work, I had to bath all of them and that was -- my reward was to get to go to the disco, which -- you know, that's not a very positive culture, I don't think.

And then, when I got to the disco, inevitably,

people got excited and there was cake and whatnot, and I ended up covered in urine and cake. And I came back down delighted that the patients had such a good time, but there was a sense the staff thought they'd got one over on the student because, you know, they thought I'd had a bad time because I came back covered in all sorts of things, when actually that wasn't my impression at all. I'd had a great time.

And so it was just a sense of the culture not being right again.

Q. And during your time -- was this during your time as a nursing assistant or --

A. Yes, as a nursing assistant. Yes, summer student.

Q. And do you know how often this hospital disco ran?

A. I don't. I think it was a fairly regular occurrence, but I might be wrong.

Q. Do you have any recollection about the staff that would be there during that time or, indeed, the patients?

A. I don't have much of a recollection. I just know, there were a lot of good staff in the hospital doing good things and there was a lot of happy patients and I wouldn't want my evidence to suggest otherwise. But there was still something that wasn't quite right and I've got to obviously explain that.

So I guess the people who are running the disco or

who ran the bowling team or whatever -- I think there were possibly work placements, but I didn't go there, so I'm not sure. My sister didn't go.

So I'm sure the staff in these individual places had chosen to go there and to run services for patients. But it was a positive experience for me, anyway, when I went.

Q. Moving on in your statement, you do, at paragraph 123, talk about children and you don't have any recollection whether there were children's wards at Lennox Castle. But were you aware of children in general being within that hospital setting?

A. I really don't have any recollection of that at all. I'm sorry.

Q. Now, turning to the medical treatment, which you talk about in your statement on pages 36 and 37 and, indeed, 38, I want to turn to paragraph 127, which is on page 37, please.

In that particular paragraph, you talk about the dental care and the input from the general practitioner. But, turning towards the bottom of that, I think you indicate that you thought certain things were not right, such as a lack of dignity and the bathing, which we have already discussed:

'I remember trying to teach the staff how to take

blood pressures and explaining what it was actually about.'

Can you tell me a wee bit more about that?

A. I can't remember what grade the staff were. But I was -- by this point, I was a medical student, so I was learning these things and I was there for my summer job. And I just recall explaining to someone about blood pressure and how you take it and what the sounds mean. And, you know, I wouldn't have been doing that with a nursing assistant because they wouldn't be doing that. So it seems odd to me the recollection that I felt the need to do that with a member of staff, but I remember doing it.

Q. Indeed you go on and say:

'I thought the amount of staffing relative to the care needs of the population that they were looking after was too low.'

I think that's what we've been discussing this morning?

A. Yes. I think, you know, you can keep people fed and watered and, you know, contained in an environment, but to do meaningful interaction with them, you need more staff to get people out and about in the community. Even within the hospital grounds, to get some fresh air and go for a walk and do all these things. I don't

think there was sufficient staff to be able to accommodate that very often.

Q. You go on, at paragraph 128, where you indicate that you weren't aware of what medication people were getting:

'I don't recall lots of people appearing to be overly sedated or anything like that. I'm aware that subsequent inquiries into Lennox Castle stated that patients were overmedicated and that nutrition was poor. That wasn't my experience when I worked there or my experience of my sister's care.'

What was your experience when you worked there about medication and nutrition?

A. Well, medication, the medication rounds appeared to happen. It was trained staff that were administering it. So I wasn't involved directly.

But they didn't -- they definitely didn't appear to be oversedated. You didn't have people, you know, sleeping in chairs or wandering around in a dazed fashion, so I wasn't aware of that.

At meal times, I can't remember what was on the menu. But I always remember there was vegetable soup and things like that. They were getting fruit and vegetables and regular meals, that I recall. And my sister was always well fed. There was no concerns there.

Q. In your role as a psychiatrist at the hospital; did you have access to the patient records about medication and nutrition?

A. I was only there once a week for a few months, when I was a senior registrar. And I wasn't actively involved, that I recall, in, actually, the treatment.

So I think I probably did see the drug Kardex at the meeting and, you know, you would see that they were on treatment for epilepsy or whatever. But I can't really comment much about it, I'm afraid.

Q. Moving on to paragraph 129, which continues on to page 38. Just before your sister sadly passed away, I understand that she was moved to Stobhill Hospital in Glasgow. There was mention in her records about a particular diagnosis of a disease.

A. Yes.

Q. Can you tell us a bit more about that?

A. So we got a phone call to say that my sister was unwell and she was going to be transferred to hospital, and I took the call. I might have been the youngest member of the family but, as the sort of about to become doctor, I got to take the call to see if I could work out what was going on.

It was a bit of a confused conversation. But there was something about a bowel obstruction, a urine

obstruction and her going to hospital and they thought they should tell me that she was bleeding when they'd catheterised her and that would be to do with her von Willebrand disease.

As a medical student, I had limited knowledge, but I had heard of that and it's an inherited bleeding disorder. So if there's an inherited bleeding disorder, families ought to be told that and be tested for it. You shouldn't be going for an operation or delivering a baby if you might bleed out on the table. But we had never heard of that before. It had never been mentioned.

So I took it upon myself to look into it and got tested myself. But, in the process, my sister died, you know, within a week, sort of thing. So they couldn't retest her because she had died. But they did get her notes and check through and although there was a mention that she had von Willebrand's, there was no evidence of her ever being tested for it. So it was unclear whether she had it, but possibly unlikely. And then -- but I had to go through testing myself because of it. So it seemed odd.

My sister was doubly incontinent and she wore nappies all of her life. It seemed odd that she would be able to have a bowel obstruction and a urinary

obstruction and for staff not to know that, because they were regularly having to change her nappies. So it was a slightly unusual situation. So it wasn't terribly satisfactory, how it all came about.

Q. I think you do say, at paragraph 130, bottom of that, that it did show suboptimal medical care, as it hadn't been clarified and the family hadn't been tested; was that your view on that?

A. Yes. Any medic would know if you've got that as a query, as a diagnosis, you should clarify it for the patient, and then, if it's confirmed, you should get the family tested and that hadn't happened. So, whether that diagnosis had been made many, many, many years before and the subsequent doctors hadn't even been aware of it because it had been written in a bit of paper somewhere in the notes, that's possible. But it did seem less than ideal.

LADY SMITH: Rhona, the condition you were referring to is called von Willebrand disease; is that right?

A. Yes.

LADY SMITH: Were the family tested after you lost your sister?

A. No, and the reason was that -- I raised the issue and was sent to the clinic where they test for it. Had my sister's diagnosis been confirmed, you know, then they

would have tested the whole family. They couldn't find confirmation and, when they tested me, I tested negative. And so they concluded that they didn't have to do any further testing.

LADY SMITH: I see. Thank you.

MS MCMILLAN: Moving on in your statement, you do tell us part of what the daily routine was like, as far as you could remember, and we can see that at paragraph 133.

Now, we've touched upon the kettle or the teapot, and we have touched upon the clothing. But I think you say that there was a lack of appropriate and individual clothing. Is it your understanding that -- certainly the clothing you described in the middle of that male dormitory; was that something that you had seen throughout the parts of the hospital that you worked in?

A. The main -- my main recollection of that was in the male -- adult male ward and I can't -- I wasn't in the female wards so much, so I don't have much recollection of the clothing there. Because my sister was in the female part, then I was mostly in the male part.

Q. You do go on to tell us that you remember the jumpers. They were patterned, brown and blue, and they were awful things, at paragraph 134 of your statement on page 39.

Is that something that stuck out?

A. Yeah, it was a job lot of crimplene jumpers. There

patterned, blue, but they were awful things. But it was the fact they were kind of all the same, and just the broken zips and the missing buttons. It wasn't ideal.

LADY SMITH: There was a reason why crimplene fell out of favour. Or maybe several reasons, as I recall it. One was its propensity for quickly building up static electricity and the other one was, as a top garment, it could give you no warmth at all.

A. So, yes, they were just kind of shiny jumpers, which weren't -- there was nothing personal about them and, in terms of being an individual, you were just someone in a jumper. It wasn't ideal.

Q. You touch on -- in paragraph 139, on page 40 of your statement -- the sleeping arrangements and we can see you say:

'I think there were at least 30 people on the ward. I don't know whether or not they had a place for their own belongings. I can't remember that.'

You again remark:

'I just remember the pile of clothes that was communal.'

You go on to say that you don't remember there being curtains around the beds in the wards. From your recollection; was there any sort of privacy on these particular wards?

A. My recollection was, in the morning, if you were on in the morning, you were going to dress the men and they were still in the bedrooms. So I don't know whether they had opened the curtains. I suspect there were curtains. But I remember just a ward of men sitting on beds. There may have been a small locker beside each bed, potentially. I'm not sure. Just there wasn't much privacy.

And the bathroom situation -- and I mentioned in the female wards, in my report, about a 'tea and pee' round, where they called it the 'tea and pee' round and it was cups of tea and then there was a row of commodes with no privacy at all. And they were taken through to sit on the commodes to do the toilet after they had had a cup of tea. And it was just awful.

So these things stick in my mind and the rest is a bit of a blur, to be honest, because it was just so against what would be good practice.

Q. It goes probably without saying, but the wards that you saw where the male patients were and the female patients were; that would be were they were sleeping as well? That was their --

A. That was where they slept. But then, again, I can't recall for definite, but my feeling was they weren't allowed in the bedrooms during the day. So I think once

they were up and dressed, they all came down to the day area. Whether it was locked off or not -- I've a notion it was locked off. But they were in the day room, which was just a big, generic space, really. Not much privacy.

Q. I want to move on now to paragraph 147 of your statement, which is on page 42.

This is a particular paragraph that talks about discipline and sanctions. I think you say in that that you don't recall someone needing to be restrained and you don't recall anybody being held down or that kind of thing.

Do you remember seeing any punishments when you were visiting your sister or during your time as a psychiatrist, or, indeed, a nursing assistant?

A. No, I don't have any recollection of that at all. I mean, it may have happened. I do recall having to grab someone's wrist myself who was known to rip nurses' dresses off. And he grabbed, to grab my dress and I just grabbed his arm, so that he didn't expose me, as it were.

But I don't remember ever seeing -- I didn't have any training in management of violence or control and restraint, I know that. I didn't have any training as a nursing assistant. I did as a doctor. And it did

happen in psychiatric wards, where you did have to restrain somebody sometimes and it had to be done properly to prevent any injury. But I don't remember it there at all.

Q. Moving down to paragraph 149 of your statement, this is something that we already touched on earlier but I think you indicated that Lennox Castle wasn't a culture where you could report things and:

'As a summer student, I would have been on a bit of a sticky wicket doing that.'

What do you mean by that?

A. There were so few staff in the ward, sometimes it was just you and the charge nurse or you and one other member of staff and yourself. Whether that was the staffing numbers or somebody was off on a break, but often there weren't many people. So, if there was any sort of incident at all, you would need to have the support of the staff around you, and so you don't want the staff against you, particularly when you know they're all friends, related, neighbours, whatever, which is how it felt. Obviously, that might not be the reality, but that's how it felt. So it did feel you were constrained in speaking up or saying anything, that's basically what I was trying to say.

Q. Now, turning on in your evidence to page 43 of your

statement, and in particular the discussion about abuse at Lennox Castle.

You go on to talk about an incident that happened when you were around 18; can you tell us a bit more about that?

A. It's the only incident which sticks in my memory that at time felt maybe something had happened, but I had no evidence to say that it had.

I was a nursing assistant and there was a trainee nurse. And I don't know the grade of the other person, possibly another nursing assistant. But it was two male members of staff. It was a sunny day and they asked if we could take some of the patients for a walk. So in my mind that was a good thing, getting out of the ward, the patients were doing something nice.

So we took some patients, some walking, one in a wheelchair. And the nurses seemed to know where they were going, so I'm just following along. We went up the hill and suddenly we came upon a sort of reservoir, which I didn't even know was there, and so we, sort of, sat down in the grass.

I wasn't comfortable because it was near water and I had vulnerable adults with me and the two male staff stripped off. I don't know if they had trunks or underwear. They didn't strip naked. But they stripped

off and dived into the reservoir and went swimming to the other side and left me with all of the patients, which felt very uncomfortable. I thought: 'My goodness if somebody walks away, I can't leave this one just sitting here'. And so I said, 'Come back' and they wouldn't.

But eventually -- nothing happened. Eventually one of them came back and said they would take one of the patients for a walk. So I thought, 'That's good', and they disappeared behind a bush and I didn't see them again for a while. And I started to think, 'I wonder what they're doing, what's happening', and I just felt uncomfortable. I couldn't say that anything did or didn't happen. But, the next thing, I heard a splash from behind the bush and the patient was in the water. And I could see their hands coming out of the water and screaming, so I shouted at the other member of staff, who was in the water swimming and they came over quickly, and the two of them got the patient out of the water and brought them back to where I was, with the other patients.

They then took the clothes off the patient who was in the wheelchair and put the dry clothes on the patient who had been in the water and wrapped the patient in the wheelchair in a blanket, and then we kind of headed back

to the ward. It just felt -- I mean, nobody was harmed. It was fine. But it -- just the whole situation didn't feel right and it didn't -- to this day, I can't remember if I did tell anyone about it. I suspect not. I think I maybe tried. But it just didn't feel safe to have the -- the people in the ward, who you were working with, if you were going to sort of report them to somebody.

I wasn't old enough or experienced enough, or felt safe enough to do that. That that was a huge turning point for me in my career, in terms of absolutely would never let anything like that happen. I would address it and I would always report things, and became the person who reviewed incidents in her own service, in my own working life.

But, yeah, that was the one time I thought there was -- something might have happened.

Q. This was your impression, as you indicated, at quite a young age, at around 18 years old, with limited medical training or experience at that point?

A. Yes.

Q. You go on and talk about -- other than that incident, at paragraph 154 of your statement, you say that:

'When I worked there, I think there was a lot of institutionalisations of both patients and staff.'

What did you mean by that?

A. I think just the general acceptance that: this is okay and this is how we do things.

And no one questioning: actually, this is not individualised, personalised, personal-centred care.

I know these terms came later in the Health Service. But, in terms of, you know, just as human beings and individuals, it didn't feel right and there was a general acceptance that this was just okay.

LADY SMITH: Rhona, can I just take you back for a moment to paragraph 152?

I see that, having described the trainee nurse coming back and saying he would take one of the patients for a walk, you go on and you mention something to do with a bush and not feeling comfortable about what was going on; can you just tell me a bit more about that?

A. I know no more than they went behind -- they walked off and went behind a bush, so they were out of view.

LADY SMITH: I see.

A. And I couldn't see what was going on. But they didn't seem to emerge from the other side of the bush and there was just an absence for quite a while, and then the next thing I knew, the patient was in the water. I just didn't know what had happened, but suspected something might have gone on that shouldn't have. No more than

that.

LADY SMITH: Thank you. That clears things up for me.

Ms McMillan.

MS MCMILLAN: Thank you, my Lady.

I think you go on, in paragraph 154, to say that there were a lot of behaviours that were accepted and unchallenged; are you able to give us any more information about what sort of behaviours?

A. I guess -- I mean, there were the behaviours of the staff, you know, the teapot and all that, the stuff where you thought: that's not what you would do at home, why would you do that here? This is someone's son or daughter. So that sort of thing.

But then the point I made earlier about, you know, if someone was maybe sitting masturbating in an open area, you might have visitors coming in, whatever, or you might be trying to rehabilitate them to go back outside, you know, there didn't seem to be anyone addressing these behaviours in order to make the chances of someone being rehabilitated better.

I can't give you a specific example, it's that sort of thing though, this sense that this is just how it is, how it's always been and no sense of challenge about it.

Q. You go on, at paragraphs 155 to 157 in your statement, to say, as you did in your evidence, that reporting and

reviewing incidents formed a part of your career?
A. Mm-hmm.
Q. And is that a result of what -- some of the things that you witnessed during your time?
A. Yes. I think a lot of what went on in my career later on. I mean, I ended up in forensic psychiatry where you are working with maybe someone who had been charged with a paedophilic offence or killing a pensioner or something like that, I think the fact I didn't judge people for their labels because I didn't judge my sister, so a lot of it goes back to my sister. And so I don't judge people, but I expect -- I always think anyone I'm dealing with, whether it's a prisoner or a patient, you know, is someone's son or daughter, and how would you want your son or daughter to be treated? So that personalised, individualised care is really, really important to me and it dates back to back then and I remember the times with hindsight to times when it clearly wasn't right and I wasn't in a position really to do much about it then and I've gone on to make that something that's important to me for my patients later on, so reviewing incidents, particular -- suicide reviews were a particular thing that I was in charge of, so the families got answers and we could try and make things better for the next person to come along, so

that's quite important to me.

Q. You mentioned there that -- something of importance is that individualised care?

A. It's huge and even now, since I've retired, I lecture in (Inaudible) about this topic, so I'm trying to raise awareness about mental illness and not judging people and doing individualised care so it's very, very important to me so I was quite attuned to it, I think, at an early stage.

Q. And then the last page of your statement, you talk about the lessons to be learned obviously from Lennox Castle and your experience, but looking at paragraph 160 you say:

'I think for staff or families that are involved with vulnerable young people with learning difficulties, education is key to understanding what their needs are and how best to help them. They also need to teach these young people how to protect themselves if that is possible and they're educationally able enough.'

Are you able to just expand on that a bit further?

A. I think the, sort of, sexual behaviour is a best example to explain it, in that we often find, with the absolute best intentions, relatives of people with a learning difficulty, particularly in the community, don't want them exposed to sexual education, don't want them to

have girlfriends or boyfriends, because they think they've got enough worries and they're trying to protect them. And there's that sort of feeling that they may not acknowledge that they do have hormones and sexual drives and they are getting older and they will have to express them or relieve them in some way and if you don't educate the parents of the importance of having to educate the young person, then they may behave in an inappropriate way.

We would see them charged as young adults with sexual offences, be it indecent exposure or attempted rape or something, and actually, most of them didn't have deviant sexual fantasies and had no intention to commit an offence. They were trying to engage with a female because they were sexually aroused, or whatever, and didn't know how to go about that.

So I think the education is important for staff, the staff in the hospitals back then who thought, 'That's just what [redacted] does,' and didn't realise that by not educating [redacted] that you would maybe do that in private in your bedroom, that actually he would get charged with a sexual offence if he got out of hospital.

So the lack of education or consequences for behaviours, which is another education, isn't it, was increasing the risk for them and their future. And so

I think that's probably the best example I can give you of why education is key and I think when I worked in the secure schools, many of the staff there had quite limited training and yet they had been dealing, you know, with some of the population's most troubled youngsters, who hadn't had appropriate role models or behavioural consequences in the environments they'd been brought up which is why they were ending up there.

So again I went back to education. I was supposed to see young people and I went back and said, 'Can I train some staff', do some staff training to raise awareness so that they're behaving responsibly with the children, so I think, right across the board, there's a need for education.

MS MCMILLAN: Thank you, Rhona.

I don't have any further questions for you.

LADY SMITH: Rhona, can I just add my thanks.

It's been really helpful having you here today to expand on your written evidence and I'm really grateful to you because it's added value to my learning and now I'm able to let you go and hope the rest of your day is more restful than this morning has been.

A. Thank you very much.

LADY SMITH: Thank you.

(The witness withdrew)

LADY SMITH: I'll rise now until 2 o'clock, when hopefully the next witness will have arrived and will be ready to give evidence. Thank you.

(12.59 pm)

(The luncheon adjournment)

(2.00 pm)

LADY SMITH: Good afternoon. Now, we turn now to the final oral witness today. Ms Innes.

MS INNES: Yes. So the next witness is Howard Mitchell, who featured in the videos that we watched on Tuesday morning.

LADY SMITH: He's the man who talked about collecting oral histories, I think, isn't he?

MS INNES: Yes, that's correct.

LADY SMITH: Yes, thank you.

Howard Mitchell (affirmed)

LADY SMITH: Thank you for coming along this afternoon to help us in this section of our case studies in which we're looking at the provision of care for children in Lennox Castle, amongst other places. Can I thank you particularly for also coming and letting me meet you in person, having seen you on screen earlier this week --

A. Oh dear.

LADY SMITH: -- as you probably understand, in a video. I know that you'll tell us a little more about that in

a few moments.

On practicalities, you'll see the red folder contains the written statement that you gave us. It's been really good to be able to have that in advance before hearing your oral evidence. We'll bring text up on the screen in front of you there as well. You can use either or neither, as you choose.

If you have any questions during your evidence, don't hesitate to ask. I have one question for you and that's how would you like me to address you? I'm happy to use your first name or your second name, whatever you are most comfortable with.

A. First name is fine, thank you.

LADY SMITH: Thank you for that, Howard.

If you're still giving your evidence at about 3 o'clock, that's when I'll usually take a short break, so everybody can get a breather in the middle of the afternoon. If that works for you, we will do that then. But if you want a break at any time other than that, just say; all right?

A. Okay.

LADY SMITH: Ms Innes.

Questions by Ms Innes

MS INNES: Thank you, my Lady.

Good afternoon, Howard.

A. Good afternoon.
Q. You provided a statement to the Inquiry. The reference for that is WIT-1-000001398. If we can just go to the final page of that statement, page 43, I think we can see that you say, at paragraph 147:

'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.'

And you signed your statement on 13 March 2024; is that right?
A. That's correct.
Q. Now, if we can go back to the beginning of your statement again, you tell us at paragraph 2 -- and we saw this in the video -- that you in fact were born in Lennox Castle Hospital?
A. That's correct, yeah.
Q. And you lived in Lennoxtown?
A. Yeah.
Q. And you say at paragraph 3 that you began work at Lennox Castle Hospital as a nursing assistant in 1975. We'll come back to that in a little bit more detail in a moment but you initially started as a nursing assistant and then you went on to train as a nurse; is that right?

A. Yes.
Q. And after you finished your training, you tell us that you went back to work as a staff nurse in the Adair Ward at Lennox Castle?
A. Yes.
Q. And am I right in thinking from your statement that you spent about six months there, in 1978?
A. I spent about six months in the Adair Ward, yes.
Q. Okay, and then you moved on to be a charge nurse in the adult wards --
A. Yes.
Q. -- for a time? And you then left Lennox Castle to begin general nurse training, in Edinburgh?
A. Yes.
Q. And, again, you say that you went back in 1982 for a six-month period?
A. Yeah.
Q. And then you were a charge nurse overseeing nightshifts at that time?
A. Yes.
Q. Then, after that, you talk about your ongoing work in different hospitals through the east, as it were. And you left the National Health Service in 1986; is that right?
A. Yes.

Q. Thereafter, you undertook some academic work and, in the course of that, you undertook -- we see over the page -- work in relation to oral history and, in that context, you spoke with people who were involved in Lennox Castle?
A. Yes.
Q. Why was it that you decided to, essentially, go back and speak to people that had either been patients or staff at Lennox Castle?
A. The department that I was studying Scottish ethnology in, the School of Scottish Studies, had a great focus on collecting people's first-hand memories. But their focus was mostly on rural, northern, often Gaelic speaking, and I felt that the sort of Central Scotland industrial belt was being missed in this focus. And while many people there were returning to what and where they knew, that was often to the north. So I thought I'd return to where I knew, er, which was the sort of the hospital set-up.
Q. If we move down the page, we see how you started to work at Lennox Castle, at paragraph 6. And how was it that you were first employed at Lennox Castle as a nursing assistant?
A. How was it?
Q. How did it come about?

A. How did it come about? Erm, a friend of mine, who was -- I was at school with, his father was a senior tutor in the hospital and he cajoled me into starting there with another friend of mine. We both started at the same time.

Q. And at this point, I think you had just left school?

A. Probably, I'd left for about nine months or so, then, and had been in various manual jobs.

Q. You note that you didn't need to have any formal qualifications to start working in that job?

A. Not as a nursing assistant, no.

Q. And thereafter, obviously, you went on to do training, as you've said.

What were your first impressions of going into the hospital and actually working there in that role?

A. The role as a nursing assistant?

Q. Yes.

A. It was very strange. I was very familiar with the hospital, because I used to go for walks, Sunday walks, round about the grounds, which were massive and open to people, so I knew the buildings. And I had been pointed out: 'You were born in that ward there'.

But I had never actually been in the buildings themselves. So it was a shock in many ways, er, about the number of people that were there and the conditions,

and the smell. But, also, there were many positive aspects as well.

Q. When you were going on walks throughout the grounds as a child; would you see some of the patients --

A. Yes.

Q. -- going about the grounds?

A. Yes, and I'd be invited to play football with them. It was always -- felt very benign and friendly.

Q. You said a number of things shocked you about it when you first went in. You said, first of all, the number of people?

A. Yeah.

Q. More than you expected?

A. Yes. The wards or villas were built to house 60 patients and, each one, 30 patients in each dormitory, er, but most of the wards at that time had more than 60. Even with 60, there was only about 18 inches between each bed and no screens or any privacy whatsoever. So that was one aspect that was quite shocking.

Q. So no screens. I suppose from a hospital nowadays, one might be familiar with having a cabinet next to a bed; were there cabinets next to people's beds for their belongings?

A. No. There was absolutely nothing at all. Underneath

the bed, there was a slide in and out, erm, sort of, cage for some personal possessions, but the vast majority of patients didn't utilise these.

LADY SMITH: And this, Howard, was in mid-1970s, was it?

A. Yes.

LADY SMITH: Thank you.

A. 1975 when I started.

LADY SMITH: Yes.

MS INNES: And were the patients in these dormitories essentially all day or did they go to a day room during the day?

A. No, they slept in these dormitories and -- which were at one end of the -- a corridor, and at the other end of the corridor was a day room and a dining room. So the dormitories were mostly empty during the day.

Q. What was the day room like? How was it furnished?

A. Erm, it was furnished mostly with chairs, right round the periphery of the wards, underneath the windows, plus an area of seating in front of a TV. But one point is that the wards all had a distinctive character, and although the architecture was all the same, the interiors were different in the ways that they were -- the furniture was. Some places had more and better furniture than others and it would be arranged differently.

Q. Did you know why some wards had better furniture than the others?
A. Erm, it was usually the number of incontinent patients that were in the ward, so special types of seating had to be provided that would withstand urine and the wards who had less incontinent patients and more able patients would have -- I wouldn't say better, but different furniture.
Q. Okay, and were there, for example, pictures on the walls or anything like that?
A. No.
Q. Was there anything personal in terms of photographs or belongings, or anything that a person might have that belonged to them?
A. Within the day room or --
Q. Within either the day room or in the dormitory?
A. I think, in most wards, most of the patients had little or no personal possessions. Most of them didn't even have their own clothes.

Erm, but some did have a degree of possessions. There were some who worked outside the hospital, who would have their own clothes. Some degree -- a transistor radio, er, and ... not too many other things than that. Maybe a book or a magazine or two, but really very, very little in the way of personal

possessions.

Q. We're talking about, you know, the issues that shocked you when you first went into the hospital, in 1975, to work. So we talked about numbers and that took us on to some other issues. You did also mention conditions. I'm not sure if you have covered the conditions that shocked you in what you have already said or not?

A. Erm, conditions. Most of the patients in some wards wore battle dress, which was leftover from the armed forces, so a sorta blue serge material. And so out of a ward full of 60 men, maybe 40 of them would be dressed exactly the same. And the conditions, I guess, of everybody sleeping together, eating together, and being with each other in such a crowded environment, you know, I guess that was another shock.

But, I suppose, how some patients were treated sometimes was also a shock, too. Erm, that it wasn't generally a therapeutic environment, as you might think of within a hospital, but more a system of containment, a long-term containment.

A question that I asked often, when I first started, was: 'Why is this -- why are they in? What's wrong with them?' And nobody could ever answer that. Or, you know, it was because the staff didn't know the conditions -- the conditions that there was in the past.

The diagnosis might have been 40 years ago and it's not always obvious why somebody has a learning disability. There are some discernible or chromosomal abnormalities, or an obvious birth defect. But, generally, learning disabilities doesn't lend itself to diagnosis, so, you know, I had a very naive perception of that. But that -- these questions at the beginning always drew no answer, a blank answer, which I found probably strange and shocking then as well, that I suppose the care environment had no sort of focus on a diagnosis.

Q. Then you also mentioned the smell. What was the smell like?

A. The smell of urine and faeces, erm, which was in some wards, again, quite overpowering. Not in them all. There tended to be wards -- they referred to them as 'low-grade wards' where the majority of patients would be incontinent, so the smell never left the environment of the dormitories that they slept in and the day room, which they spent the majority of time in during the day.

Q. I'm going to come -- I'll ask you just in a moment about the issue of 'grading' that you have referred to there.

But again, going back to your first impressions, you said there were the things that shocked you, but you also said there were some positives; what were the positives?

A. The majority of the nursing staff and the untrained auxilliaries, er, were generally very, very kind and caring.

If I can separate this. So, when I first started, there was what was called the 'hospital block', which was ostensibly for patients who were ill, but that wasn't really the case. Some were frail, and some just generally landed there and stayed. So that was quite a separate environment from the general adult blocks there, and the nursing staff and the regimes were a bit different there.

So, when I refer to saying a lot of the -- or the majority of them were very kind and caring, that was the first impressions there in the first couple of months, when I started.

Q. In the hospital block?

A. Yes.

Q. So, rather than in the villas, because you weren't working there on a day-to-day basis at that time?

A. That's right, yeah.

Q. Okay. Now, you mentioned that patients were referred to or were, perhaps, accommodated according to different grades.

A. Yes.

Q. We understand that some were referred to as low grade,

some were referred to, I think, as medium grade, and then high grade?

A. Yeah.

Q. So can you tell us what was meant by, first of all, 'low-grade' patients?

A. Well, erm, they would be at the bottom of the bell curve of intellectual ability. So, generally, they might have multiple disabilities, might be doubly incontinent, unable to speak, and many unable to walk or move about much. There were a number of these patients.

Q. And then who were the patients who were referred to as 'medium grade'?

A. They -- this is gross generalisations, but they may have some words, better comprehension and more ambulant. And sorta higher grade patients were at the top end, if you say that, may exhibit capacity that you wouldn't know whether they had a learning disability or not and be able to leave the hospital, work, or do jobs within the hospital and generally give a good account of themselves.

Q. Were patients accommodated according to those gradings?

A. Very, very loosely, yes. Wards were designated: 'That's a low grade ward'.

And this low grade -- these were terminologies under Acts of Parliament. You know, these were the official

terminologies, rather than ones that the hospital made up.

So the low-grade wards would have a majority of low-grade patients. But, in order for the hospital to run properly, there'd be some higher grade patients there as well to help with the routine of the work of the ward.

Q. So some patients were helping. When you say they're helping with the routine of the work in the ward; what sort of things were they doing?

A. Er, they were helping with the laundry. The number of wet beds and soiled clothing was immense, so they all had to be collected, bagged, and put out for the laundry van to come and take this to the laundry. And then, when the laundry van returned, the patients would take the laundry in and distribute it about the ward. So that would be one.

Meals as well. There'd be patients who would go out to the meal van, bring the receptacles into the ward there. A bit of cleaning, although, as I've referred to, the domestic staff were -- started to be employed in the seventies. Prior to that, the patients had to clean the floors and the walls of the villas, but there'd still be -- even after domestics were employed, there'd still be some patients who helped the domestics in

cleaning.

Q. On that topic, we can see on the screen just now paragraph 38 of your statement, and that refers to the children's wards. You say that there wasn't the same delineation of grading within the children's wards and it was more of a mix of abilities.

A. Uh-huh, yes.

Q. But you refer there to say it was rare for children to be looking after other children in the way that you have discussed. But did adult patients come to help in the children's wards?

A. Yes.

Q. I think you mention helping with feeding?

A. Yes.

Q. Perhaps also with -- did they help with cleaning in the children's wards as well?

A. Yes, some of them changed some of the children if they were wet.

Q. Would that be done under supervision of nursing staff or not?

A. Not always, no. No.

Q. Now, if we go back in your statement to page 3 and paragraph 9, you talk about -- this is the point where you talk about going back to the hospital again, having done your nurse training?

A. Yes.
Q. And you went to work in the Adair Ward and you chose to work there?
A. Yes.
Q. I think you go on to describe that you were running a sort of playgroup environment?
A. Yes.
Q. Can you describe what that involved?
A. It involved, erm, taking, probably, 18 or 20 of the children from the ward, maybe about 100, 150 metres away, to a separate building, erm, which was ostensibly a playgroup environment. So an attempt to do music and play, and keep them entertained. Yeah.
Q. How many children would be in that group?
A. I think it was about 18.
Q. Was that all of the children who were on the ward?
A. No. It was the children who could walk, because they all walked there, and who had some degree of comprehension. Some had very good comprehension, but some not so much, but it was felt might benefit from that environment. But, also, and probably most critically, who were deemed to be educable and able to move to the building next door, to the playgroup building, which was staffed by teachers.
Q. Okay, so how old were the children in the group that you

were looking after?
A. Between 4 and 15.
Q. So while it's described as a 'playgroup', which we might think is perhaps for pre-schoolchildren, perhaps; actually some of the children that were in the playgroup were older --
A. Yes.
Q. -- and of school age?
A. Yes.
Q. And when you say that it would then be thought that they could move next door to the school, or to the classroom; how would that come about, that they would progress on to school?
A. They only moved into the classroom, the teaching environment, for a short period of time. Maybe 30 minutes at a time for their daily dose of education.
Q. So you would have them in the playgroup and then they would go through to the classroom --
A. Yes.
Q. -- for, as you say, half an hour or so of education?
A. Yes.
LADY SMITH: And you called that their 'daily dose'; would that be all they would get in a single day?
A. Yes.
LADY SMITH: What age group was this?

A. Erm, this was from 5 to 14.
LADY SMITH: Thank you.
MS INNES: And this was on the Adair Ward, and we understand there was another children's ward, the Leslie Cox Ward?
A. Yes.
Q. Were children from that ward also were going to a similar playgroup and then to school?
A. I believe so, but I don't know for certain.
Q. Okay. Can you remember if there was any particular distinction between why children would be in Adair, rather than Leslie Cox?
A. The Leslie Cox had more able children and most of them were ambulant. A lot of the children, probably about 50 per cent of the children in the Adair Ward, weren't ambulant.
Q. If they weren't ambulant, but were still able to have some kind of education; was that being offered to them?
A. No.
Q. And what were they doing during the day when --
A. They were sitting in the ward.
Q. On their beds or in a chair?
A. No, in the day room.
Q. Right. Sorry, in the day room.
A. Sorry, I'm saying the 'ward' as a whole for the building.

Q. Okay. Moving on again in your statement, at page 4, you talk about coming back to Lennox Castle, at paragraph 11. You refer to moving on from the Adair Ward to working as a charge nurse. At that time were you working in one of the villas?
A. Yes.
Q. And was that with adult patients?
A. Yes.
Q. And when I say 'adults'; were all those people in the ward over the age of 18?
A. No.
Q. How young would the patients have been on the ward?
A. One was 12, in one of the wards, but not when I returned as a charge nurse. One I worked in during my training, there was a boy who was 12 there.

In the wards I worked in as a charge nurse, there'd be some -- certainly -- 16, 17-year-olds and some 16.
Q. Okay, and how would it have come about that these boys had been moved to an adult ward?
A. I wouldn't be involved in any of that decision-making. But I believe they'd be thought to have been too big, active, challenging for the Leslie Cox Ward.
Q. Then you say, as you have said, that in 1982, you went back and covered nightshifts for a period and you were based on a particular ward, but you would visit other

wards during those shifts?

A. Yes.

Q. Now, if you just bear with me a moment, please.

(Pause)

If we move on to page 5, please, in this section I think you're talking about some of the things that you became aware of when you first worked there, and you talk at paragraph 14 of there being a frenzy of activity.

In paragraph 15, you said:

'It was a mad frenzy of work, work ... then sit back, relax and tell stories. The narratives that were exchanged round about breaks were hugely significant at the time and on reflection as well.'

Can you explain that, please?

A. The narratives would be around about different patients who were there, patients of the past, staff who were there and staff of the past. So it gave me some kind of insight into the history of the institution and how and why things came to be as they were at that time. There were narratives about how dangerous some patients were. Erm, how they had assaulted some other patients and how they had assaulted members of staff, erm, but that was one aspect.

Generally -- sorry, I'm trying to remember what my

point was in saying that. Certainly, it gave me a taste of what I went on to study and research, in that personal narratives are so valuable in formal and informal situations and that was probably the start of my interest in what became my profession in the end.

Q. In the next paragraph you talk about, again, what they were saying, the staff in these breaks. And then, towards the second half of the paragraph, you say:

'They might have seven staff working on a shift. They all worked and they all had a break together.'

A. Yes.

Q. Who was looking after the patients when they were on --

A. Nobody.

Q. Sorry?

A. Nobody.

Q. Would they be having their breaks, sort of, in the ward in kind of view of the patients or would they be away in another room?

A. No, in another room.

Q. At paragraph 17, you say:

'As a nursing assistant, I felt embraced by the whole system.'

A. Yes.

Q. 'Once I started training and went to other places and learnt good practice, I started to reflect.'

So can you explain a little bit more about that? What do you mean by you 'felt embraced by the whole system'?

A. There were very many kind people who -- a lot of women who probably felt quite maternal towards me, and I felt that warmth from them. They recognised, you know, I was a very naive young boy, so they did their best to help me. And I felt that warmth from many of them, but that was, again, initially.

But, generally, in the initial years of working there, it was a very welcoming place and a very social place, so there were lots of people to be friends with and lots of social situations that the people within the hospital did together as a group with -- so it was a very social entity.

LADY SMITH: When you are talking about the social entity and people in the hospital doing things together; are you talking about the staff?

A. Yes.

LADY SMITH: Thank you.

MS INNES: You go on over the page, at paragraph 18, to say:

'There was very little turnover of staff.'

A. There were new people starting all the time. Very few people leaving, unless they're going on to, like myself, do further training. But, generally, there wasn't a big

turnover.

Many people started there and worked there all their working lives until they retired and, even when they retired, they'd come back on nightshift for a couple of nights. So, you know, it was that kind of environment, yeah.

Q. You say at paragraph 18:

'That creates a certain kind of environment for good and for bad. Things are allowed to grow and things are allowed to fester.'

A. Yes.

Q. Can you explain what you mean by that?

A. Well, the negative side, as I think I've said, it's very difficult to get rid of somebody unless they're very, very bad. Certain people and certain practices were tolerated because people socialised together, because there were a lot of family connections within the hospital. Some had three generations or so, and then when you sort of move that out, there were cousins and aunts and uncles. So that was within the whole staff environment. So it was quite difficult to, as the current terminology is, 'call somebody out', because you'd have all these layers of relationships.

Q. You mention that at the bottom of the page, about being difficult to get rid of people. You mention:

'... who weren't patient orientated and unprofessional, who were either anachronistic or outright cruel and took advantage of their positions of authority.'

You go on to explain that that's one of the things of some people who are in a position of looking after people with learning disabilities. You say:

'The flaws in people's character can be very easily nurtured by the power they have over the people that they're looking after.'

A. Yes.

Q. And were there people like that who worked there when you were there?

A. There most certainly were, yes.

Q. At paragraph 22, you refer to staff frequently giving patients nicknames. You say this is more, in your experience, in the adult wards?

A. Yes.

Q. And the nicknames don't seem to be particularly pleasant?

A. No.

Q. You say:

'The individuals would be aware that they were being called those names.'

A. Yes. For example, say ... Piggy. I remember one

nursing assistant who worked in the ward where this individual, Piggy, I'll call him 'Piggy [redacted]'. But, for example, Piggy [redacted], somebody came to the door one day and asked if [redacted] was there and this nursing assistant, who had worked in this ward for a couple of years, said, we don't have a [redacted] here, we've got a Piggy [redacted], so she didn't know his real name. So this is an example.

Q. Okay. Now, if we can move on a little in your statement -- if you just bear with me a moment.

(Pause)

At paragraph 29, on page 9, you talk about the range of people who came in to the hospital. You said the range within that was huge. I think you have alluded to that already.

Was there any sense of providing for the individual needs of the patients?

A. Erm, it was on a very ad hoc basis. Providing for -- it was more providing for the needs of the wards in the hospital, it seemed to me, rather than the needs of any individual patients. You ran a good ward. You ran a good hospital, in that there would be little trouble or little complaint or little commotion. So the ethos didn't seem to be to cater for any therapeutic needs, but to cater for keeping people in line, really, so that

nobody caused trouble.

Q. Was there any difference between adults and children in that therapeutic sense?

A. A little. But what began to be introduced, when I was working with kids, was behaviour modification techniques and there were some nurses sent to be -- to train as behaviour modification experts and some psychologists come into the hospital as well. It was round about challenging behaviour, preventing challenging behaviour and encouraging children to be continent.

So that seemed to be the limit, rather than trying to fulfil anybody's potential and try and, erm, help people to get to a position where they could leave the hospital, which many -- my contemporaries and people who -- I'm about to say 'enlightened', but not very enlighted, necessarily. But felt that the ethos of any place like Lennox Castle should have been preparing to move into better circumstances, away from the hospital. But that didn't seem a priority in the majority of the hospital.

Q. Now, on page 10 of your statement, you talk about the staff structure at the hospital. At paragraph 31, you refer to the role of the physician superintendent at the time that you were there and he seems to be in charge of everything?

A. Yes.
Q. Is that right? And they lived on the grounds, I think?
A. Yes.
Q. You mention that there were some other doctors there. We know from, other material, that there were relatively few doctors in comparison with the number of patients or the nursing staff; is that correct?
A. Yes. Each senior medical member of staff would be allocated several wards under their care with the physician superintendent and his deputy being above them in terms of management structure. So the -- any visits were done by these senior medical staff to the wards, but there were also doctors who would be there for limited periods of time to do -- have insight into learning disability for their psychiatric training.
Q. Would the doctors be doing ward rounds on a regular basis or not?
A. Regularly, once a fortnight sometimes, yes.
Q. You mention, at paragraph 33, that there was also an element of physicians doing research?
A. Yes, erm, given that there was so little in the way of medical necessities through the hospital, some of them did a fair bit of research into some of the syndromes and abnormalities or the allergies that would cause learning disabilities.

Q. We know, I think, that there was some research into drugs, sort of drug trials. I don't know if you were aware of any of that going on during your time at the hospital?

A. No.

Q. If we can move on, please, to page 12, paragraph 39, this is where you were talking about patients being involved in caring for other patients, essentially.

At the end of paragraph 39 you say that:

'The relationship wasn't necessarily mutually beneficial. It wasn't always well done. There was often a co-dependency, not just among the children. Decades of co-dependency meant that there was abuse going both ways.'

What do you mean by that?

A. That some patients would be paired up, so that a more able patient would look after a less able patient. Sometimes the more able patient would be frustrated and might strike the less able one or not care for them properly. So that was abuse going down the way.

The abuse to the more able patient was that they were tasked with coping with and caring for this less able person, often during the day and during the night.

Q. Right.

A. There were a number of relationships that would start,

certainly in the Leslie Cox Ward, of that co-dependency and go on for decades as they moved into the adult wards.

Q. So one patient, essentially, has always been responsible for and looked after this less able patient, and that continues through their lives?

A. Yes.

Q. At paragraph 40, you refer to a juvenile section having been there historically. You say that in the 1950s, there was a physician superintendent who took an interest in juvenile delinquency, which was a moral panic at the time, and he welcomed quite a lot of juveniles to the hospital.

Now, this section didn't exist, I don't think, by the time that you worked there?

A. No, that's right.

Q. But you've read about this or you've heard stories about this.

A. Yeah.

Q. Now, it seems a bit different, if we go on over the page, you say that the juvenile ward was for those aged 12 to 16 or 18:

'It was for teens who were bunking off school or stealing bikes or deemed slightly to be on the spectrum of learning disability.'

So that seems to be quite different from other patients who were in the hospital who, perhaps, had profound disabilities?

A. Yes, erm, but most of the wards did have one or two of this type of person as well, so it wouldn't be unknown -- no, it would be common for most wards to have several people who were on that spectrum, who might go into Glasgow at the weekends and sorta be taken for quite a fully functioning person not living in a hospital ward, but a member of the public.

LADY SMITH: You mentioned there, Howard, them going on runs and marches throughout the town; that's the juveniles in this ward?

A. Yes.

LADY SMITH: What did they do?

A. When they went on the runs and marches? Erm, well, again, I didn't witness this. This is secondhand. But there would be maybe about 20 of them supervised by members of staff and it'd just be exercise, to go for a run.

LADY SMITH: But not within the grounds, into town?

A. Within the grounds as well, yes. Just a wider area to exercise in.

LADY SMITH: Thank you.

MS INNES: At the bottom of page 13 that we're looking at

there, at paragraph 44, you refer to girls, I think, that perhaps had been in Waverley Park and then were transferred into Lennox Castle.

A. Yes.

Q. And then on to page 14, at paragraph 45, you say:

'Some of the talk amongst the staff would be about why the girls were in there. Some of them might be there because of circumstances in their home or family lives. They might have been involved in prostitution or they weren't being looked after properly. They were open to exploitation and living in terrible circumstances.'

These might seem to be the reasons that had given rise to them ultimately coming into Lennox Castle?

A. Yes.

Q. Then you refer, further down that paragraph, to:

'One of the bizarre aspects was that case notes weren't held on the ward.'

A. That's correct.

Q. You say:

'That certainly wasn't the case in Gogarburn.'

Where you had also worked?

A. Yes.

Q. So that wasn't a practice that was going on throughout other hospitals?

A. No, not to my knowledge. No.
Q. What impact did the lack of accessible case notes have on the ability of the nursing staff to care for the patients?
A. I think it had a huge impact, because it sent some kind of message that the individuals didn't really matter. You weren't looking at individuals, any kind of aetiology, any kind of social background. You were just dealing with 60 people who were in front of you on a face-to-face and daily basis, rather than any kind of planned care programme.
Q. I suppose one might ask: how could you properly care for a child, for example, if you didn't know what specific vulnerabilities or risks, or needs that they had?
A. Yes. And the rationale then would be getting to know someone from within the ward staff group. Given that many members of the nursing staff wouldn't be with them for many years, then the knowledge of the history, certainly within the wards, would be there within the staff group.
Q. So you would rely on other staff members, essentially, to give you some kind of --
A. Yes. And I think the charge nurses within the ward would have more depth of knowledge than nursing assistants or student nurses, or staff nurses there.

They would have had, perhaps, conversations with the medical staff.

Q. At paragraph 49, on page 15, you refer to the children's wards, which were similar to the adult wards that you've described, no curtains. And then you say there was no privacy between beds before then. They put curtains in, in the mid-1980s, you say. Then you say:

'After people had got dressed and gone for breakfast, they put some soft toys on the beds. I don't know if it was some kind of signifier that it was a kids' ward, not that the kids ever got to play with the soft toys.'

So these toys appeared and were put on their beds for what purpose?

A. Decorative.

Q. For whose benefit?

A. I don't know.

MS INNES: Right, it's 3 o'clock.

LADY SMITH: Would that be a good point to break, Ms Innes?

MS INNES: Yes, thank you, my Lady.

LADY SMITH: Would that work for you, Howard, if we took a short break at this point?

A. Yes.

LADY SMITH: Let's do that then.

(3.00 pm)

(A short break)

(3.10 pm)

LADY SMITH: Welcome back, Howard. Are you ready for us to carry on?

A. Yes, thanks.

LADY SMITH: Thank you. Ms Innes.

MS INNES: Thank you, my Lady.

If we can move on to page 17 and paragraph 58 of your statement, you talk about communal clothes, which you have already mentioned, and you mention them in the adult wards. You say:

'In the Adair Ward, the kids had individual clothes that belonged to them however they were only utilised at weekends and on Wednesdays, which were visiting days. If the staff knew a relative was coming to visit, then they'd have their own clothes and the rest of the time they would have communal clothes.'

A. Yes. Although there'd be some --

LADY SMITH: This is at paragraph 58, isn't it?

MS INNES: Yes, sorry, on page 17.

LADY SMITH: Thank you.

A. That probably wasn't universal, in that some kids would have their own clothes on a day-to-day basis, but the majority didn't. But it was the case that if there were visitors coming, they'd get -- certainly get their own

special clothes out.

Q. And you mention there being visiting on Wednesdays and at the weekends?

A. Yes.

Q. So at the time that you were there; was there not more open visiting?

A. That had been -- these had been the visiting hours for decades. And while there were some visits outwith that, it seemed to suit everybody to continue with that particular regime.

There was a bus that came from Lennoxtown up to the hospital itself, the visitors' bus, so that ran on Wednesdays and Saturdays.

Q. And was that -- that doesn't sound like a public service bus; it sounds like a bus specific to Lennox Castle?

A. Yes, it was a hospital bus.

Q. Okay. Right.

If I can move, please, to page 18, and at paragraph 61, you refer to the playgroup and the half-hour educational input that you've talked about.

You say that you were keeping them engaged in activities, but leisure time involved limited walks. The impression that I have from your statement is that the children didn't have a lot of time outdoors?

A. No, they didn't.

Q. You refer to there being a playground, but some of the items in it were broken, I think?
A. Yeah, there was a grass area with swings and an old sort of iron horse and roundabouts that was just across the road from the ward, erm, but that was in disuse and the children never played there when I was there. And there wasn't a lot of time spent outdoors, apart from walking to and from the ward to the playgroup.
Q. And you say at the bottom of paragraph 62:

'The kids in general didn't play with toys in the same way as they would in a home environment. That was partly due to their individual disabilities, but it was also because they weren't taught to play. I think you need to be shown examples of playing and it wasn't generally a kind of play environment. It was a regime environment, rather than a play environment.'

Even for children?

A. Yes.
Q. You've mentioned the soft toys in the bed, but were there other toys around for them to play with?
A. Very little. I can't recall any toys within the ward. There were toys within the playgroup, but not in the ward itself.
Q. Now, if we move on, please, to page 21 and paragraph 68, you talk about communication. You say:

'Things were done to help a child communicate if the child was non-verbal, but it was very individual.'

And you talk about a particular example of trying to communicate with a particular child.

Then you say:

'You were fighting against the weight of scepticism and trying to get everybody to be part of the uniform ward population.'

So that's something that you were also fighting against, I think?

A. Yeah.

Q. Can you explain that a bit further?

A. I came up against the weight of maybe some of the regular trained staff not wanting to make any particular patient a special case and do something different with them, that's -- and the scepticism of just trying to improve anybody's life as well, because that wasn't seen as the work of the ward.

Q. What was seen as the work of the ward?

A. Getting things done, keeping people -- feeding people, keeping them clean and out of trouble and mischief.

Q. Carrying on, on page 21, you talk about the medical records, which you've mentioned. And then, at paragraph 70, you say that there was supposed to be an annual review by the medical staff. So that seems to

have been a sort of formal annual review that was supposed to happen?

A. Yes.

Q. What form did that take?

A. Sometimes a quick physical inspection. But, mostly, it was just sorta hearsay from the ward staff: 'How are they? Getting on okay? Fine'.

So somebody would -- may have ten years of a one-line input every year saying, 'No change, doing okay'.

Q. In the hidden history programme, you looked at some of the records that were held at the hospital. One of the things I think that you looked at were day books. If I could ask you, please, to look at NHS-000000117, first of all. This is an excerpt from a daybook from 1949, I think we can see.

A. Uh-huh.

Q. And the first entry -- it might be slightly hard to read, but it's 7.00 pm to 7.00 am, night report. And then there's reference to somebody sleeping all night:

'All other patients slept well.'

And then if we look down to the next entry, 7.00 am to 3.30 pm, day report, and there's reference to some people having minor fits. Somebody referred to as 'still noisy' and somebody who perhaps had some

sickness, it says:

'No further sickness, though troublesome at times.'

There's reference to somebody being quiet.

Is this the sort of record that you found when you looked at the historical day books?

A. Er, yes. Although there were separate ones that there were -- a -- punishment books as well and escape books. These are historical. By the time I was working there, the daily report was in a tear-out form that was carbon copied, so you'd write out for a shift what happened in that shift and it would be carbon copied through and you'd get the -- a patient to take the report to the office, the nursing management office.

Q. If we could look, please, at NHS-000000081. This is a daily report and I think we see, if we look at the left-hand side: 'Female ward, 46 plus 1HW', whatever that means.

It says:

'18 February 1984.'

A. Yeah.

Q. And then there's a pro forma, which refers to, I think, certain activities that patients might be doing and it says it's Saturday, it's a rest day. So 46, I assume, were having a rest and then one of them, I think, was in the hospital ward. So 'HW' must be the hospital ward?

A. Yeah.
Q. And then the report on the other side is for the Sunday, in February 1984, and it seems to be quite similar in terms.

Are these the proformas that you had that you can remember, or is this something different?
A. These are different to the ones that I knew. Now, it may be that this was an update to the ones that I was familiar with, but they're similar. There also used to be a difference between the male and the female side of the hospitals. It wouldn't surprise me if they used slightly different reportage as well.
LADY SMITH: Howard, over on the right-hand side, the last entry of the list reads:

'Wearing special dresses.'

What was that all about?
A. I'm intrigued myself. I --
LADY SMITH: It then has '(locked)'; do you see that?
A. I think it might be a reference to moleskin dresses that used to be worn.
LADY SMITH: As a punishment?
A. As a signifier of running away sometimes, in the past. But also for people -- patients who might tear their clothes.
LADY SMITH: Right. I see, because it's harder to tear

moleskin?

A. Yes.

MS INNES: Now, if we can go back to your statement again, please, and to page 22 of it, at paragraph 72, you talk about some medication that was being given to patients. You refer to Largactil and Mellaril being used to sedate and control behaviour in some cases?

A. Yes.

Q. And you say that they would be used on children?

A. Yes, less Largactil than Mellaril, but yes.

Q. And then if we go on to paragraph 73, you refer to paraldehyde, which you say was being phased out by the time that you were in Lennox Castle. It had more of a sedative effect and you had to use a glass syringe because it melted a plastic syringe?

A. That's correct.

Q. And you say:

'The terminology was "the needle": "You behave or you'll get the needle".'

A. Yes.

Q. That was used by staff to patients?

A. Yes.

Q. And did you ever see that being used with children or not?

A. No.

Q. You say that some medication would be written up 'PRN', so as necessary; did that apply to both children and adults or not?
A. Yes, both children and adults.
Q. I think you are talking there about paraldehyde:
'It did feel that there was a correlation of it being used as a punishment.'
Thinking about the sedatives that were used in relation to children; did you have that same sense that it was used as a punishment or not?
A. No. No, thank God.
Q. What was the purpose of it being used with children?
A. For children, I guess the rationale would be hyperactivity or aggression, and there certainly were some of the kids who were aggressive and destructive, so it would be behavioural-based.
Q. Then, at paragraph 74, you refer to medication being given on a trolley, and you say:
'There was a culture of memorising everybody's medication.'
You have maybe spoken about this in some of the videos that you have done as well?
A. Yes.
Q. Did that also apply in the children's ward?
A. Yes.

Q. How could you be confident that people were getting the right medication?
A. Well, I guess, speaking from their perspective, if they're doing it every day for five years, then they're confident that it's the right medication that they're giving. But it's -- I'm certainly not condoning it at all and, as the seventies went into the eighties, that tightened up quite a lot, I believe.
Q. If we move on, please, to page 25 and, at paragraph 81, you are talking about work, which we have already referred to.

Then you talk about money from paragraph 82, and you say that if patients were getting money, or cigarettes, for example, that system could be used to discipline patients; was that for children or adults?
A. For adults.
Q. Just to be clear: did it apply to people that were over 18 only?
A. No, no, within the adult wards, when some of the patients were under 18, that would apply to them as well.
Q. So, if they were there at the age of 16, for example, then a sort of disciplinary system could have been used by withdrawing finances or cigarettes?
A. Or withholding what the finances bought, which would be

sweets or juice, or cigarettes, yeah.

Q. If we can move on, please, to page 27, again at paragraph 91, you say:

'I don't think there was much differentiation between children and adults amongst the staff. It was all part of the same thing, apart from the educational input.'

You say:

'In fact, when I worked within the children's ward there was certainly a perception that if there was money available for any facilities then it wouldn't go to the kids. It wasn't a priority.'

Why was that? Do you know?

A. I don't know why it was. But I certainly know that it was a perception and a reality as well. I could only speculate, which probably isn't of any use here.

But the money that was spent on -- fixtures and furnishings within the adult wards didn't seem to be replicated within the children's wards. The children's wards weren't a priority, as you might think that children's wards should be, because children have much more potential.

Q. If we move on to page 28, you speak about disciplinary procedures for staff at paragraph 93. You say that there would be verbal warnings and, ultimately, people

could be fired:

'It was more an informal type of discipline rather than by the book.'

What do you mean by that?

A. That somebody would have a word with somebody and warn them or talk to them, rather than anything being documented. Again, I say there the hospital ran on relationships rather than formalities and, within these relationships, discipline could be maintained.

Q. At paragraph 94, you refer to a specific incident, where somebody was dismissed for having physically abused an adult patient. At the end of that sentence, you say:

'There was informal punishment by staff and that happened regularly.'

What do you mean by that?

A. (Pause)

There were many types of punishment from not letting somebody go to the pictures or the dancing -- so removing social opportunities from them. So, again, that was to do with regulating the ward environment. There were undoubtedly some members of staff who slapped some of the patients within the ward environment, as some punishment.

Q. At paragraph 95, you say that you did feel able to challenge some of the behaviours and practices, and then

you go on to say that you would challenge them on a one-to-one basis, rather than officially reporting?

A. Yes.

Q. Why would you not officially report it?

A. Because it was endemic within the hospital. And if you reported one instance of this, there'd be, possibly, dozens and hundreds that should also be reported, erm, and I felt at the time that it would be more effective to talk and find out why people did it or explain why they shouldn't do it, rather than say this is against -- in actual fact, I did say: 'This is against the law. You won't -- if you do it when I'm here, I will report you'. But, as I say, it did go on throughout the hospital.

I also make the point that at that time, these people would be slapping their own children as punishment as well, and that was many people's explanation: 'That's what I do with my own kids', you know, 'Why shouldn't I do it with them?'

Q. You say that there in the paragraph that's up on the screen now:

'In the Adair Ward, there was smacking of children.'

A. Yeah.

Q. Top of the page, just above paragraph 96, you say they would be smacked across the wrists or backside and

'occasionally smacked across the face'.

A. Uh-huh.

Q. Whereas in the Leslie Cox Ward, you heard that 'no child could have a finger laid on them' because of the regime laid down by the charge nurse?

A. Yes.

Q. So it was dependent on the charge nurse, essentially?

A. To a large extent, yes, but also on the rest of the staff within the ward. The charge nurse could -- certainly would be the major influence on what happened within the wards, yes.

Q. Then, at paragraph 96, as you've said, within the Adair Ward, when you were qualified and you were a staff nurse, you said, as you've just said, there should be no smacking. There was an outcry about that, as you have explained. At the end of the paragraph, you say:

'It worked a bit, but I'm sure it still happened behind my back ...'

A. Yes.

Q. What makes you sure about that?

A. (Pause)

Because I feel that I was only -- it was only something that was effective when I was there observing, and that most of the people I talked to weren't convinced by my arguments.

Q. If we can move on, please, to page 31, and paragraph 105, where you talk about several patients being physically restrained and routinely tied to chairs, and there would be a rationale given for that. But you say that you never saw this form of restraint; did you see any form of restraint being used on children?

A. No, I didn't see any form of restraint being used on the children.

Q. Did you see restraint being used on, perhaps, over 16-year-olds that were in adult wards?

A. No.

Q. Do you know if restraint was used for young people of that age or not when you were there?

A. No. I don't know of any instances of that, no.

Q. If we move on, please, to page 33, you talk about some of the things that were reported to you, that we have seen about people having to do domestic chores, people having been put on a regime of bread and milk. I think you say that didn't happen. You never saw that happen, rather, when you were there; is that right?

A. That's right.

Q. And you then talk about, at paragraph 112, a punishment ward; did you ever work on that ward?

A. I did, yes. I suppose that I referred to it as a

'punishment ward'. It would probably be more correctly referred to as a secure ward.

Q. Was it locked?

A. Yes. The perception was it was the punishment ward. It wasn't officially termed that.

Q. Were -- 16-year-olds, for example; did they go to this ward or not?

A. Er, yes, I'm fairly sure I knew one 16-year-old at least who was in that ward, yes.

Q. And were you aware of any issues of abuse between patients?

A. There were lots of fights between patients, physical fights. Erm, I'm not -- I don't think exploitative abuse, but merely -- 'merely' is not the right word, but physical violence towards each other in an argument situation.

Q. Would staff try and break these fights up?

A. Yes.

Q. At paragraph 113, you say:

'There were a lot of insidious things, like preying on people's weaknesses.'

Can you explain what you mean by that?

A. Just knowing what to say -- basically, knowing what to say that would annoy or hurt a patient. Knowing something about their background, about their relatives,

about their friendships, about their sexuality, something that would give an in, to tease a patient.

Q. Why would staff, who were there to care for the patients, do that?

A. Again, it's about power and control, and the wrong people being in a position of care.

Q. If we go on to page 36 and paragraph 121, you talk there about, you know, more widespread, perhaps, environment of physical abuse. You say people took that to their work and behaved like that in inappropriate settings:

'There was also undoubtedly an element that people could get away with it because they were dealing with people with a learning disability ...'

You say that they would not retaliate against them personally or 'retaliate against the system that was pressing down upon them very heavily'.

Within that, do you mean that the patient would not be able to report or communicate to somebody else what had happened, to try and stop it?

A. Yes. Both being unable to physically deal with it, but be powerless to make anybody believe that they had been assaulted. And also that they wouldn't be able to communicate at all, some non-verbal patients.

Q. If we go on to page 37 and paragraph 126, you referred to a ward that you worked on as a student nurse, and you

say:

'An older patient used to help them out by putting them to bed and washing.'

This ward included younger people from the age of 16 to 20, and you looked into the ward and discovered the older patient masturbating one of the physically disabled patients. You reported that to the charge nurse. What was done about that?

A. Nothing, to my knowledge, at all.

Q. If we move over the page, on to page 38, and paragraph 130, again this is in relation to reporting behaviour or challenging practices. You say:

'There was a defensiveness on part of the staff that outsiders didn't understand their work at Lennox Castle. [You say] There was also a lack of representation and voice for nursing staff. They were victims, too, of established practices, difficult conditions and a powerful medical presence.'

Can you expand on what you mean by that?

A. Very many of the nursing staff felt that the hospital wasn't doing a good job and that they wanted to do things better for the people within their care, and they felt held back by many things within the hospital. The physical conditions; they had 70 people within one ward that was built to house 60 people. But these 60 people

were still living 18 inches -- or sleeping 18 inches away. It was hugely overcrowded.

There were great problems in controlling 70 very challenging individuals with two or three staff. So that whole thing, be it an excuse or there was a reality round about it that all that many people could do was manage a bad situation on a day-to-day basis to the best of their ability. And that they couldn't break against the system that they were in to try and do any better.

Q. I suppose there's also the question of if they were working in such conditions and feeling so powerless; why did they stay and continue to work there?

A. Some didn't. Many did. And, as I think I mentioned, it was quite well paid over some of the jobs that some of the nursing staff might otherwise have been working in and there was an element of, for some people, to have control of a small environment, fed some kind of ego as well.

There were very many things that overcame the frustrations and that helped people to put up with the situation that they were in. Erm ...

Sorry, it's a complex thing.

As I say, many people did stay because of the economics and many people left because of the frustrations. What many people didn't do was officially

report things that they felt were wrong and illegal because they felt there was no point.

Q. Why did they feel there was no point?

A. Because they felt the hospital was some kind of entity in itself with all the power, and that the hospital wasn't working towards the care of the patients. The hospital was -- had another purpose.

Q. What was that purpose?

A. The continuation of its entity.

Q. Okay.

A. Sorry, that's awful nebulous.

LADY SMITH: No, no need to apologise, Howard. I understand what you're getting at. This was a place that had been established for so long it had a personality of its own, almost a right to life of its own, maybe some people felt.

A. Yeah.

Q. If we move on to page 42, paragraph 141, here you are talking about the work that you then did in speaking to people who had been either staff or patients at Lennox Castle.

You say there were different conflicting issues that you've referred to, essentially, in your evidence: the position of the staff, the position of the patients, the local community, the history. All of these issues.

And then at paragraph 141, you say that you were trying to manage various conflicting issues and then in the next sentence you go on to say:

'It was also about trying to admit that it was obvious the people who had lived in Lennox Castle as patients were victims. They were victims of a terrible period of institutional and care history. They were abused by the system and they were abused by individuals. I think that's obvious for anybody with any care, compassion or insight to see.'

Does that remain your position?

A. Yes. The system -- the place -- when they built the place, it was seen as a hundred years ahead of its time, they said in the Glasgow Herald, and a civic success in building a place where these poor people could be looked after. But you can't build a hospital where 60, 70 people are living side by side and have two or three people look after them and expect this to be a therapeutic environment.

So the way it was set up, I don't think there was any chance of any of the patients who lived there being cared for adequately from the start. So they were abused by the system from its very beginning and, along the way, individuals abused them as well, on a one-to-one basis and in their administration of the

hospital.

Q. If we go down to paragraph 142, at the end of that paragraph you talk about:

'A wider societal responsibility about why people ended up there and the motivations of those who had relatives there.'

Can you explain what you mean by mentioning this 'wider responsibility'?

A. Throughout the centuries, society has wanted to lock people away because they didn't fit in, they posed a threat, and at various times, there's different tolerances or intolerances.

At the time the hospital was built, or the 1913 Mental Deficiency Act allowed for the building of separate hospitals for people with a learning disability, this was thought always a kindness, to take them away from the mixture of psychiatric illness or penal care and to have somewhere that was of therapeutic form.

But it became just a repository because there couldn't possibly be any therapeutic care because of the numbers involved. It could only be a custodial care. And there's always swings and roundabouts about who poses a threat or where money should be put towards different people at different times.

Now, there is -- there are many more resources for people with learning disabilities, but still there's questioning about how those resources should be managed and where they should be put. And the budget is a big thing when we talk about care and therapy.

Q. If we go over the page, at paragraph 145, you refer to a project that you did with Garvald, Edinburgh, and you talk about the -- you say it was a most refreshing place for supporting people with learning disabilities that you've ever seen, or it was the most refreshing place. And you talk about the types of things that -- the creativity that people are able to, I suppose, unleash, the staff that are working there, and it's a completely different attitude.

A. Yes.

Q. And that appears to be seeing people as individuals?

A. Yes.

Q. Is that right?

A. Yeah. And also not as carers for somebody, because caring often imbues somebody with power, as well as responsibility. And not all people who are in positions of care can handle the power over another individual very well. And if you work with somebody and you're not a carer, but are working on a task and you're equal, the power balance becomes very, very different and that side

of things was very, very evident within the sort of workshops that I observed in Garvald, Edinburgh.

Q. So you are working alongside somebody, as opposed to being in power over them, I suppose?

A. Yes.

MS INNES: Thank you, Howard. I have no more questions for you.

A. Thank you.

LADY SMITH: I don't have any other questions either, Howard. But I do want to thank you again for everything you have given us by coming here this afternoon, to add to the written evidence I already had from you.

Thank you for your thoughtful and reflective evidence and for being so frank about so many things. I really appreciate that.

A. Thank you.

LADY SMITH: Please feel free to go and have a restful evening. I think you've earned it.

(The witness withdrew)

LADY SMITH: That's the end of the evidence for today.

Can you give us an outline for next week, Ms Innes?

MS INNES: Yes, my Lady, on Tuesday we will continue to hear evidence primarily focused on Lennox Castle.

On Wednesday, we will move to applicant evidence in relation to Ladyfield, which will also be on Thursday.

On Wednesday afternoon, we will have Ann Gow from Healthcare Improvement Scotland and, on Friday, at the very end of the week, we'll move to St Joseph's.

LADY SMITH: Thank you very much for that summary.

I hope you all have a good weekend and I look forward to seeing you on Tuesday morning, 10 o'clock. Thank you.

(4.02 pm)

(The Inquiry adjourned until 10.00 am on Tuesday, 6 May 2025)

INDEX