Tuesday, 6 May 2025

(10.00 am)

LADY SMITH: Good morning, and welcome to week 2 of our case study hearings in relation to this phase of our work, looking into healthcare, additional support needs and disabilities provision for children.

Now, we start this morning with a professional witness, I think; is that right, Ms McMillan?

MS MCMILLAN: Yes, my Lady, thank you.

The witness is Gillian Anderson. She is a professional witness in that she worked in psychology, or is now a retired psychologist, but is able to speak to her experiences of dealing with vulnerable adults who disclosed childhood abuse, my Lady.

LADY SMITH: Thank you.

Gillian Anderson (affirmed)

LADY SMITH: Thank you for coming along this morning to help us in this part of our case study hearings. It's really good to have you here. I'm grateful to you.

Thank you, also, for engaging with us to provide a statement in advance. That's enabled me to know what we're going to probably cover with you, although we won't go through every part of it in detail, obviously.

First question I have for you, I hope is an easy one: how would you like me to address you, your first

name or second name?

A. My first name.

LADY SMITH: Thank you for that, Gillian.

If you have any questions at any time or you think we're missing something that we should be asking you, please don't hesitate to speak up. So far as timing is concerned, we may be finished with your evidence by 11.30, but, if we're not, I usually take a short break then, so you can work to that. But if you want a break at any other time for any reason just say, will you?

A. Okay, thank you.

LADY SMITH: Thank you.

Ms McMillan. When you're ready.

Questions by Ms McMillan

MS MCMILLAN: Good morning, Gillian.

A. Morning.

Q. Now, I understand that you provided a statement to the Inquiry. The reference for that is WIT-1-000001414.

I think, hopefully, you should be able to see that in front of you now.

A. Yes.

Q. Can I ask, firstly, for you to have a look at page 18 of the statement. That's the very last page. We can see, at paragraph 55 of that, 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.'

Is that still the case today?

A. Yeah.

Q. We can see that it was dated on 8 April last year?

A. Yeah.

Q. And signed by you.

A. Yeah.

Q. Thank you. Now, turning back to the start of your statement, please. We can see, at paragraph 2 of your statement, that you talk about your background. I understand that you have an honours degree in psychology; is that correct?

A. Yes.

Q. And then a masters in clinical psychology?

A. Yes.

Q. And during the course of your career, you worked in the NHS Forth Valley Greater Glasgow Health Board?

A. Yes.

Q. And latterly, from about 1995 to 2022, you worked within NHS Lanarkshire?

A. Yes.

Q. That was as a clinical psychologist?

A. Yes, yes.

Q. And you say that all of your posts involved working with adults with learning disabilities, including assistant posts?
A. Yes.
Q. Has that's been throughout your career?
A. Throughout my career, yes. I only had a brief spell -- although I was working in learning disabilities, I did a session in mental health in my first job, in Forth Valley.
Q. And what is it you do now?
A. I'm retired. I do nothing.
LADY SMITH: I'm sure you don't do nothing.
Q. Now, from paragraph 3 onwards, you tell us that before you retired, you were a lead psychologist in learning disabilities. What did that role involve?
A. Basically, the role was about ensuring that the psychological services in NHS Lanarkshire to adults with learning disability were appropriate to that population. So we had to ensure that we were providing the best or the most evidence-based services, psychological services, to adults with learning disabilities through assessment and interventions, training, et cetera.
Q. And you said interventions and assessments; what sort of thing do you mean by that?
A. So would it make sense just to, sort of, maybe describe

a bit of a -- you know, what would happen if someone was referred to us, for example?

Q. Please. That would be helpful. Thank you.

A. Yeah, so within the service, I worked in a multi-disciplinary team. Psychology was part of that and people were referred through either other members of the team or other services within the area, so it could be social work, for example. Social work was our biggest referrer, but other support services could also do that.

So, when somebody is referred into the service, they are usually referred with an issue or a reason for referral, which could be, for example, somebody has behaviour that people find difficult. That could be a reason for referral. Sometimes known as 'challenging behaviour'.

When we pick up that referral, we go and see the person. We will see their carers. We will assess the situation. That might be through observation. It might be through complete and particular types of assessment, and then we will decide what the intervention should be, in collaboration with the person and their carers.

For example, with behaviour that was difficult, we would be looking at how we would support that person in a positive way to change their behaviour and there would

be various types of interventions involved in that.

Q. Now, I think you do say this at paragraph 11 of your statement, on page 4: that a lot of your referrals come from social work?

A. Yes.

Q. And we can see there that you don't get many referrals from the GPs?

A. Yeah.

Q. Is there any particular reason for that?

A. Largely because -- I suppose, historically, learning disability services were hospital services, so you were referring people from within hospital. When we became teams, we were almost like a secondary or a tertiary service. So we did get GP referrals and we were probably starting to get more of those. But because most of the people would be living in a supported-type environment, so they might be in a -- supported by a support organisation or there were still some residential care services. They were the people that saw what was happening and they were the people that made the referrals, and social work were the main link pins for those. So, again, it was often social workers that would make the referrals to us.

Q. So it tends to be, perhaps, people who were more aware of that individual's behaviours or needs?

A. Yes, of course, mm-hmm.
Q. You talked a wee bit there about the sort of interventions that you would put in place; are you able to give us an example of what those interventions would involve?
A. Yeah. I'll give you an example because it's mentioned in the statement. One of the interventions we used was behavioural family therapy. So it's a very prescribed intervention, whereby you go through -- it's roughly 15 sessions where you work with the person and their family and it's around supporting the family to change their behaviour. So it can involve -- it involved things like communications, supporting the family to look at their communication, change their communication or modify their communication to make it more positive.

But, also, looking at them making -- setting goals and aims for themselves. Sometimes you find in families, the person with the disability is taking up a lot of the family time, if you like, and that a lot of the focus is on that person. And it's trying to support the family to live in -- you know, so that each member of the family is participating and there's no one specific focus.

So that would be the -- so it would be communication, maybe some work on anxiety or mood

management, and setting goals and aims for each individual member of the family.

So that's one specific intervention that we did use and was part of the service provided within NHS Lanarkshire.

Q. And, presumably, when such an intervention is put in place; is it something that's done on a multi-disciplinary approach?

A. Behavioural family therapy was. There would be two people carried out that intervention because you're working with the whole family, but not all interventions. There were some interventions that were purely done by psychologists. There were some interventions that were purely done by nursing staff or psychiatrists or other members of the multi-disciplinary team.

Q. And was it often the case that you would work as a team to decide on the most appropriate interventions?

A. Yeah, the way that worked was when somebody was referred to the service, they were screened by one of the nursing staff, a member of nursing staff who worked in the locality that they came from. So there was a screening done to look at what their needs were and, from that, referrals were made to the most appropriate services. So that could be psychology, it could be psychiatry, it

could be nursing as well, speech and language therapy, et cetera.

At that point, each individual who was referred, the person, would go in and do their own assessment. But there were times where some people had multiple needs, so it was more appropriate if the assessments were done jointly or the interventions were -- maybe not so much carried out jointly, but done together -- like the -- I might work with, for example, a speech and language therapist. Their intervention might be different, but doing the two together might be more helpful for the person and more appropriate for the situation.

Q. And when you talk about the individuals that you would be involved in and making assessments and interventions, you've mentioned the phrase 'challenging behaviour'?

A. Yeah.

Q. Can you describe, in a general sense, what you mean by that?

A. Well, I suppose 'challenging behaviour' is probably the older term for it. But it's behaviour that would be perceived to be challenging. I think it would be called now -- certainly when I retired, that's what it was called, it might have changed now. But, basically, it's the types of behaviour that are of a frequency or intensity -- they put a person's -- they put the person

at risk or other people at risk.

So it can include things like aggressive or violent behaviour. It can include things like self-injurious or self-abusive behaviour, where people are injuring themselves. It can include things like people making themselves sick. People maybe faecally smearing, things like that. These are some of the things that people can find difficult to manage, and that's what I would say 'challenging behaviour' or 'behaviour perceived to be challenging' means.

LADY SMITH: Gillian, is it important to recognise, if you do use that word, that it mustn't be assumed that the person behaving that way intends to challenge you?

A. Absolutely. The term 'challenging behaviour' was meant -- was originally coined -- I think it was in the early 1980s and it was originally coined to -- because before that it was called 'problem behaviour'. And it was to kind of underline that the challenge was to the service to rise to that challenge and meet the challenge. In fact, the paper that coined the phrase was called 'Meeting the Challenge', but it was to take the onus off the person. It's not their -- the behaviour is not the problem. It's something that's happening to that person or something that they've experienced that might be behind that behaviour and

that's what we have to do something about.

LADY SMITH: And so you have to remember it's not to challenge, as in challenge somebody to a fight?

A. Yes, exactly.

LADY SMITH: Yes.

A. Uh-huh.

MS MCMILLAN: Now, Gillian, moving on, I think, to paragraph 12 of your statement, we can see that on that page.

A. Yeah.

Q. You begin to talk about some of the disclosures of abuse incurred by adults in your service.

You say that they reported all forms of abuse: physical, sexual and psychological. Are we to understand from this that, when they were making those reports, they were children or young adults?

A. No. When they were reporting to me, they were adults, but they had happened when they were children.

Q. Moving to the next page of your statement, at page 5, paragraph 13, Secondary Institutions - to be published later Secondary Institutions - to be published later I think you go on to say at the bottom of that:

'The people that I saw were all people who might have been described as having a mild learning disability.'

Can you tell us what you meant by that, 'mild learning disability'?

A. Yeah, a mild learning disability is somebody whose learning disability generally doesn't affect their functioning to as high a degree as people -- what might be easier is to try and -- and I don't really like doing this, but describing it with an IQ, because that's how people with learning disability are described in terms of -- so somebody with an IQ of below 70 would be assumed to have a learning disability. So somebody with an IQ of between 55 and 70 has a mild learning disability; 55 down to 40 has a moderate learning disability; 40 down to 25, a severe learning disability and 25 and below, a profound learning disability. It just refers to the person's intellectual abilities and how that impacts on their ability to function as an ordinary adult, an ordinary person.

So people with mild learning disabilities, you might think they may be a bit less academically bright than their peers, but probably can manage most activities of daily living, can get through life. They might need a little bit of support. They usually have language, are able to communicate. Whereas people with severe and profound learning disabilities would not be able to.

So that's kind of what I'm kind of referring to

there.

Q. I think you go on, and you do say that in the next sentence of your statement:

'They would probably have been thought of as a little bit slower than their peers, but possibly not thought of as having a learning disability at that time.'

A. At the time, yeah, mm-hmm.

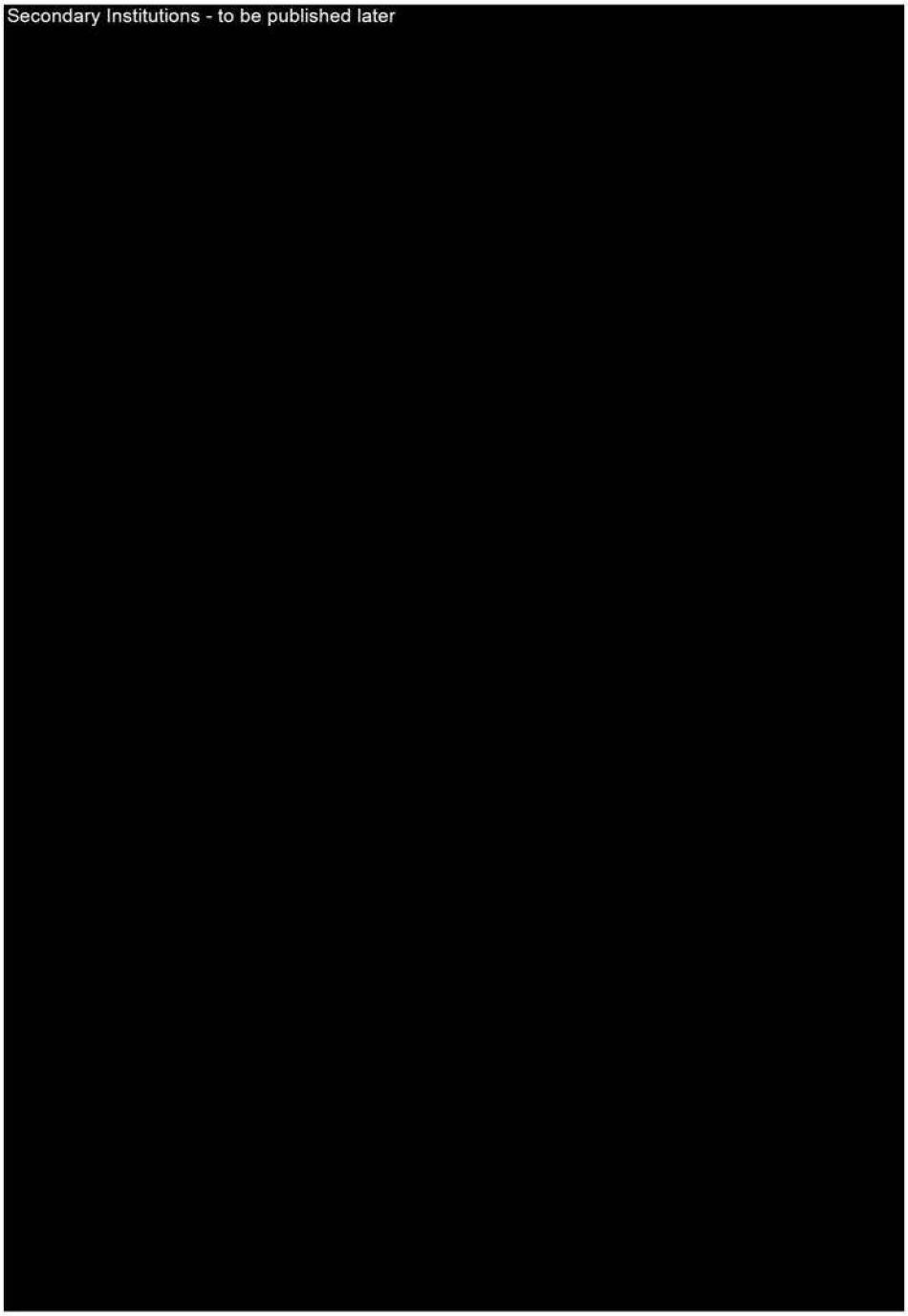
Q. When you say 'at that time'; is that when they were children?

A. Children, yeah.

Q. From that, are you able to tell us what your opinion is on them, for example, being placed in care? Is it possibly because of the prevalence of the mild learning disability?

A. I think that particular institution -- this is my thinking from what I was told, because it had closed and I don't actually know. But I think that institution was for children who had behavioural issues or had -- their behaviour within the mainstream school was difficult to manage. So it was a residential school placement. So I suspect there would have been people there who didn't have a learning disability or children who didn't have a learning disability. I don't think it was specifically for children with learning disabilities,

but for children whose behaviour was causing concern.



Secondary Institutions - to be published later

Q. Now, looking at paragraph 17 of your statement, you begin that paragraph by saying:

'None of the people that made disclosures to me spoke about medical restraint, such as use of sedatives. The reason I don't think anything was said about that is that a lot of people with learning disabilities think that receiving medication is the norm.'

Can you expand on that at all for us?

A. I think if you look at -- well, certainly in all of my career, most people I worked with were on some form of medication, either medication that would impact on psychiatric symptoms or sedation-type medication that would reduce agitation, for example.

A lot of people with learning disabilities or a significant proportion of people with learning disabilities also have epilepsy, so a lot of people were on epilepsy medication as well, and some people were on quite a cocktail of medication.

So, at night, when they got their cup of tea or whatever, they often got their medication with that. So it was like a normal thing, if you like, and I use that advisedly. But people didn't mention receiving medication and I know certainly in some of the hospitals I worked in, people would ask for their 'jag'.

Now, their 'jag' was as-required medication for

agitation. People sometimes asked for it because they knew they were getting agitated and that would make them feel less agitated. That didn't always happen. But people were aware that it was for their agitation. But they didn't see it as -- you know, they wouldn't have said ...

People would tell you if they'd been restrained, you know, physically restrained, but they wouldn't talk about medical restraint, because that was seen as more -- I don't know why, but it was seen as more normal, it certainly seemed to be.

Q. So did you maybe gain the impression that, perhaps, some of the individuals didn't necessarily know what the medication was for. But it was, for example, if they were feeling agitated, to calm them down. That's what they would expect to get.

A. Yeah, I think probably, earlier in my career, people were on tablets, medication, that they probably wouldn't have known exactly why they were on or what it was for. But as-required medication is quite specific. It is specifically used for agitation. So, if people are starting to get wound up or agitated and there's particular -- I mean, it's -- it's very well, kind of, policed, if you like. So there's only certain circumstances under which it should be used and that

should be lain out quite clearly. But the person receiving it, it's maybe not always clear to them exactly why. They just know: 'I feel a bit like this', and that's then what happens next.

So they make that connection and sometimes start asking for that. And it can be -- some people receive as-required injections, but, mostly, it's tablets. So they will say, 'Can I get my tablet, can I get my tablet', as well. That's another thing that can be asked.

But I don't think they would -- and again, this is absolutely my thoughts on it -- I don't think they would see that as restraint in the way that we might but --

LADY SMITH: Gillian, do you know what drugs they were being given?

A. It varies. One of the -- one of the -- the sort of benzodiazepines were generally used for as-required medication, so something with a sedative effect. There are other things as well.

Some of the medications that were used quite heavily when I started my sort of career were things like chlorpromazine, thioridazine. There was lots of epilepsy medications used. Things like lithium. Mood stabilisers were also used that, you know -- and still are. You know, there's still a lot of -- and, to be

fair, I haven't read the research recently, but, even, you know, towards the end of my career, polypharmacy was quite a big thing in learning disabilities and I know, certainly, the psychiatrists I was working with were working to reduce that as much as possible.

But people had been on, sort of, high levels of medication for a long time.

LADY SMITH: Thank you.

MS MCMILLAN: Now, going on to the next part of your statement, you begin to talk about the prevalence of abuse amongst -- and risk of abuse to children with learning disabilities.

Focusing on that, at paragraph 18 of your statement, you say that:

'All through my career, child abuse has been a massive elephant in the room. It was something that I would ask about in any kind of therapeutic situation.'

Can you tell us more about that, please?

A. Yeah. I think when I first started -- and it was 1992 I qualified, I think there were -- there was a lot more -- things were starting to be raised about child abuse.

I think up until -- I don't know, I couldnae tell you when, but child abuse was seen as not something that didn't happen, generally. And it's only in the last, I think, 50, 60 years that we've started to recognise that

it does. It did and it still does.

And I think I mentioned later on -- when I was a trainee, there was -- I don't know if it's Panorama or World in Action, or something like that was on the television about child abuse and, the following week, two women who I saw at the clinic I worked in, in my placement at the Southern General, both disclosed abuse that week because it had been -- you know, I think things like that were helpful as an impetus to get people thinking about it and talking about that.

But, I mean, one of the first books I read about it was called 'It Doesn't Happen Here' and it's about, sort of, learning disability hospitals and the fact that abuse happens there and it happens in residential placements with people with learning disabilities and it's been happening for a very long time. It was an elephant in the room because people didn't acknowledge that. They do now. But, at that time, or leading up to that time, it wasn't acknowledged in the same way.

And when I first started working, we didn't really ask about it. But one of my supervisors had said to me: if you don't ask, people won't tell you. So in any assessment you do, you should ask. You don't have to ask the question, 'Were you abused as a child?', but you

can say, 'Can you tell me a bit about your childhood?'.

One of my supervisors said: 'Do you have a happy memory about your childhood?' or 'What was a not so happy memory?' And then you can maybe move into: 'Did anybody harm you as a child?', and you can, sort of, gradually get into it that way. But, if you don't ask, people will not tell you about it.

And it's now pretty much standard that you would always ask about that in an assessment situation.

Q. During the course of seeing patients and asking those sort of questions; did you notice, for example, like a shift in change from when you first began your career or towards the end of it? Were people happier to talk about it? Not happier, but able to talk about it, I think is probably --

A. I think there was that. But, also, I think it became more acceptable to talk about it as well, and I think it wasn't just about us asking those questions.

But there were things -- there was quite a significant, again, documentary-type programme, MacIntyre Undercover, where he spent a period of time in a residential care home for people with learning disabilities. And people with what I called milder learning disabilities earlier on, would see and hear these things, you know, and it became more talked about.

People with learning disabilities; there are now a number of advocacy organisations. There are a number of, you know -- people are taken seriously, so ... they are certainly taken more seriously than they were 20, 30, 40 years ago.

Q. And then you also say in that paragraph, just towards the bottom:

'From what the research says, people with learning disabilities are one of the groups that are most likely to be abused. A lot of them can't tell on their abuser.'

What did you mean by that?

A. I think -- I expand on it a bit further on, but I think people with learning disabilities are one of the most -- the groups most likely to be abused because they're very dependent on other people for care, support and protection. So, even an adult -- you know, as children -- I think we know that children are more likely to be abused for those very reasons because they're very dependent on people for physical care, to feed them, for emotional support, everything.

But people with learning disabilities often continue in adulthood requiring a lot of support and care and are very dependent on other people.

LADY SMITH: Yes, I think you deal with this at paragraph 19

and 20, don't you, a bit further on, yes?

A. I think I did mention it a bit later. So there are also -- I mentioned, you know, people -- some people don't have language or their communication is compromised and they struggle to actually disclose abuse. So what we have to do is rely on their behaviour telling us what's going on. And there's a lot of research and a lot of work being done on that to, kind of, identify what behaviours might be consistent with a history of abuse.

So, yes, they are at more of a risk and I think there's a number of different populations that are more at risk, including children, older people, people with mental health problems, et cetera, because of their vulnerabilities.

Q. And picking up on one of the specific vulnerabilities that you mention at paragraph 20 of your statement, you say:

'People with learning disabilities are often very isolated. If someone shows an interest in them or shows them any affection, that could be seen as a positive by the person with learning disabilities.'

What did you mean by that?

A. Well, I think if you're very isolated and somebody becomes your friend and tells you you're special, you're

a person that they're interested in, that's -- I mean, I think we'd all feel good about that, even though that's not the intention from the person. And that's certainly some of the abuse that came to light with us, was people actually talking about their very positive relationships with somebody. And it wasn't, but that's how it was viewed, because the person took an interest, they were kind to them. But they were also using their time with them to abuse them.

LADY SMITH: They were, in fact, grooming the child. Yes.

MS MCMILLAN: Going to the next paragraph of your statement, at paragraph 21, you say:

'Going right back, Lennox Castle was exposed by a television programme. That led to a lot of new builds and changes to the system.'

Can you tell us, from what you remember, about some of those changes?

A. Well, I believe -- I worked in Lennox Castle from 1993 to 1994, and there had been the new -- Riversides 1 and 2 were the sort of assessment unit and the behaviour unit. And 'the huts', as they were known, had been closed. They were effectively -- well, from what I can gather -- they weren't there when I was there, but they had been what was seen as punishment blocks. People were put in the huts if they misbehaved or did something

that wasn't seen as -- that's what I was told. I didn't experience that. They had already gone by the time I was there. But, you know, there was quite a lot of money poured into making it -- and making the environments -- because the environments, there were very large Victorian wards there. But the two new units were, like, 12 bedded, people had their own rooms and things like that. So things had changed a bit and systems had changed a bit.

Q. Just touching on then the time that you worked in Lennox Castle; I think you indicated that was between 1993 and 1994?

A. '94, mm-hmm.

Q. What was your role at Lennox Castle at that time?

A. I was the clinical psychologist to the behaviour unit, as it was known. And the two of the wards that were -- housed people with behaviours that were perceived to challenge.

Q. And within these particular units; do you remember what the rough age ranges of patients were?

A. It was fairly broad. They were from -- the youngest person I saw in Lennox Castle was 18 and the oldest was in her 70s.

I think probably the majority would have been in their 30s and 40s. But there was a -- you know, there

was a fair age range.

Q. The particular units then that you were working in; what part of the hospital were they based?

A. At that time, there was what was known as the upper site and the lower site. I was based wholly on the lower site and there was 1 and 2 Riverside, 3 and 4 The Boulevard and 2 Glazert Drive were the wards I worked in, because they were all, like, addresses, if you like. They were all, sort of, streets or -- so they were the names of the units that I worked in.

Q. I think we have heard evidence before that there was, almost, the hospital area of Lennox Castle and then there's smaller off-shots of that?

A. Mm-hmm.

Q. Were you involved in one of the smaller units then to the site?

A. I was wholly hospital-based. I was wholly hospital-based. Are you talking about Filyman and places like that?

Q. Yes.

A. No, I was wholly hospital-based.

Q. The units then that you did work in, you had mentioned the, sort of, Victorian wards; is that how they appeared when you were there?

A. No. The two -- the Riversides were new builds, so they

were 12 bedded units. One was an assessment unit and I would work with people who were admitted there. They often didn't stay very long. Sometimes they did move into the main hospital, but that was an assessment unit.

So it wasn't always me that worked in there. Some of the other psychologists, they'd work in there because if it was people that came from their area, they would work with them. If they hadn't seen psychology before, I would work with them.

And 2 Riverside -- I can't remember which way around it was. I think 1 Riverside was the, sort of, behaviour unit. That was a 12-bedded unit as well, and that was longer stay. That was more seen as a sort of a treatment unit-type -- you know, people went there for interventions.

And The Boulevards were old wards, but they had been refurbed a bit. So there were still four or six bedded dorms in there and not any individual rooms.

And Glazert was like that as well, 2 Glazert Drive was like that. Two -- but they weren't, like, the sort of -- I think the top site had -- and I didn't really have much -- in fact, I didn't have any input up there. But they, apparently, had, like, big -- you know, a massive room, with 20 beds down one side and 20 bed down the other. That sort of thing.

Q. You mentioned that one of the units that you were in was a treatment unit?
A. Yeah, that's how it was known. It's not the best of names. But, yeah, that's how it was known. Uh-huh.
Q. Was the intention being that anyone who was in there would be in that unit for a shorter period of time?
A. The intention was, yes, that -- it was there -- it was to be -- to be provided with inputs and interventions that would eventually lead to them being moved out of the area and into their own -- back home or into their own place, yes.
Q. And from your time working within that particular unit; would you be able to say how long someone remained in?
A. While I was there ...

Most of the people that were there were there for most of the time I was there, but I was there for only a year and a half. I'm trying to think if -- I can't honestly remember if anybody went out. There must have been, 'cause some people did come in. So -- but, I think the intention had been that it would be something like six months to a year, I think, if I recollect correctly. But, you know, it wouldn't be -- it wasn't a long stay part of the hospital.

Q. Again, the patients who would be admitted to the treatment unit, as it has been described; would you be

able to talk about their age ranges? Was it in that kind of bracket you have given before?

A. Again, no -- well, yeah, pretty much. The youngest was probably about 25 and the oldest, when I was there, was probably in their 50s. Yeah, I think probably 50ish. So that sort of age range, I think.

Q. I think you had indicated you were there for about a year?

A. A year and a half.

Q. And a half.

Going back to your statement, I want to skip on, certainly, to paragraph 25, on page 9. This is you, I think, talking at this point about reporting and responding to abuse. You say here in that particular paragraph:

'It was mainly roles which were disclosed to me, such as being there at night or teachers. The people involved were night staff and one of the teachers at the school, but nobody mentioned any names.'

To understand that paragraph, what seemed to stick out was the roles that the abusers had?

A. Yeah.

Q. Can you tell us anything else about that?

A. I guess -- I mean, I suppose opportunity is part of, you know, an abusers role. Who has the opportunity? And

somebody who works there at night, with the kids in their beds, that is the prime opportunity, I would have thought, for an abuser. But other than -- I mean, I think that was more -- people didn't really talk so much about the abusers as more as what had happened because it was clearly very traumatic, what had happened.

But -- and I don't know as well, you know, sometimes thinking about people and their names is pretty traumatic as well, so I don't know if that had anything to do with it, them not mentioning names. But, yeah, I think it's people in positions of power, you know, erm.

Q. And was that the impression that you gathered from some of the disclosures; that it tended to be people in positions of power?

A. Generally, yes, uh-huh. But I think that's often the case in abuses. Somebody that has a bit of power and is able to wield a bit of power over somebody else.

Q. Now, moving again to the next page of your statement, skipping on slightly further to page 10 and paragraph 30, you then talk about the reporting, in this paragraph, with people with learning disabilities. And you say you think:

'The biggest factor that prevents people with

learning disabilities from reporting abuse is that they can't report. They either don't have the language or they're not able to report.'

Just touching on that point, firstly: are you able to provide us with any more information about that?

A. Well, I think in terms of not having language, I mean, there's a number of people I worked with, we were pretty convinced something had happened to, but we had no way of being able to find out what that was through their behaviour, through what they did, and how they acted with people. And they couldn't tell us and we couldn't find out, because it wasn't happening at that point. But we're pretty sure it did. And we can only surmise. We can't, you know -- so that's -- I don't know if that helps any?

I think also, erm --

LADY SMITH: Gillian, if it's any help to you, it makes perfect sense to me, I've heard from people who don't and didn't have learning disabilities, who were children in care, but didn't report. And I have a vivid memory of one witness saying to me: 'I just didn't have the lexicon for it'. And that captures what many people have said. How could they explain?

And that separately from that, some of them would have the powers of reasoning to work out what the pros

and cons of speaking up were and reckoned that the cons were such they didn't want to run the risk.

A. Yes, yeah. I think that is the case and I think also people with learning disabilities, and children as well, if you're not believed, if you report and you're not believed or if nothing happens, then what's the point?

LADY SMITH: Yes.

MS MCMILLAN: And then I think you go on and then say:

'I also think that the experiences that they've had may well discourage them from reporting.'

Is that what you mean by 'belief' or is there something else that you mean in that statement?

A. Yeah, about being believed. If they're not taken seriously about other things -- and, I mean, you know, I've seen people with learning disabilities being treated very, you know -- people just sort of, 'Yeah, yeah', pat on head and that's fine. But they don't take them seriously and they don't listen to what they're saying.

So I think they've lots of experiences of not being listened to, not being believed, not being encouraged to say anything. So -- and I think things are getting a lot better.

I mentioned things about there's now a number of advocacy groups. We are trying to redress the balance

a bit. But it will take a while to get -- you know, 'cause I think still -- there are still situations where people with learning disabilities are not given the credence they should be.

Q. And when you are talking about that struggle, when they are, you say, sort of patted on the head or almost just put to the side, from your experience working as a clinical psychologist for a number of years; are you able to tell us what the effect of that is on someone with, sort of, mild or learning disabilities?

A. I think they're sort of fairly wide-ranging. For some people, they became quite -- what's the word I'm looking for? Not reticence. That's not the word. But they just -- they didn't speak up or didn't say anything, it wasn't worth it.

Some people became more -- you know, their behaviour might have been seen as a bit more challenging. They did other things that maybe came to the attention of people. But, you know, I think that's true across the board; that's not just people with learning disabilities.

I think if you're not listened to and if you're told that you're not worth listening to, you start believing it and don't bother. But, yeah ...

Q. Thank you.

Now, turning to paragraph 33 of your statement, which is on page 11, you say that:

'We were getting people from the age of 16 to 18 onwards. I would say that there were a lot of people coming, towards the end of my career, who had reported abuse or abuse had been discovered in childhood.'

So was this a change from the start of your career?

A. In terms of the age or in terms of the reporting of abuse?

Q. Both.

A. Well, the age, yes. Previously, it had always been 18 onwards. But we -- if people were not in full-time -- because, again, like, going back to what I was saying earlier, most of -- you know, most of the services 30, 40 years ago were hospital-based or residential-based services. But they're not anymore.

So people who are not in full-time education, they would come to us at 16. People who were in full-time education would come to us at 18, which is pretty similar to the mental health services ages, although I believe that's changing now in CAMHS as well. The ages are changing. But that was a slight change. But I would say that we were an awful lot more aware of people who had reported abuse or abuse had been discovered in childhood and what was being done about

it.

Q. From that we can gather that's probably a fairly positive change?

A. Yeah, I would say. Uh-huh.

I think probably -- sorry, but I just think one of the biggest changes -- or one of the most positive changes is ensuring that staff are au fait with the signs of abuse, are trained to recognise that, you know, and are trained in how to respond when they discover it, which I think is massive, because it's usually a member of staff that somebody will go to, in my experience. It's usually a member of staff that they trust, that they will speak to. So that, to me, would be -- and that's certainly been happening a lot more. You know, we did a bit of training with staff. We would do that. And that's something that is more integrated into services now. People are aware that it happens. People know more what to look for, et cetera.

Q. So, as a staff member working with adults or, you know, 16 to 18-year-olds, staff are now trained in how to respond to those disclosures of abuse?

A. Yes, absolutely.

Q. Moving to page 13 of your statement, and paragraph 40, at this point, you are talking about the impact --

LADY SMITH: Ms McMillan, somewhere a telephone is ringing.

I don't know if it's coming through on the Webex. It's stopped. Thank you.

MS MCMILLAN: Just turning back, at this point, you're talking about impact here. We can see that you say in that paragraph:

'Across the other people I saw who had been abused in care, I saw them because they were seen as being difficult people.'

I guess it's touching on that 'challenging behaviours' phrase that you had already been talking about in your evidence. But 'difficult people'; what do you mean by that?

A. Well, I think they were -- largely, the five people that I mentioned were all referred to us because their behaviour was viewed as challenging. So they were all referred to us for those reasons. And when you started scratching the surface a bit, you discovered that there was an awful lot more going on.

And a couple of them had already disclosed and were aware that that was probably where this was coming from, so that was -- we were able do a bit of work with them around that. But it's something that -- you know, these were things that happened and some of them were just awful and it will affect them for all their life. I'm not sure how much we can do to make it any better,

if that makes sense?

Q. Turning, again, on in your statement to page 15, it starts at paragraph 48. But it's page 16, halfway through the paragraph that I just want to ask you some more questions about.

You talk about the lessons that the Inquiry can really learn, and you say that you:

'... would be trying to prevent abuse rather than dealing with the consequences.'

What sort of things do you think that we can be doing in that prevention element?

A. I think there's been a number of things that have been done in the past and are probably still being done. But things like -- I think it's called the HeadStart programme or the something-start programme for parents, single parents or parents with -- who had difficulties themselves supporting children from a young age. And I think things like that can help to support parents to provide appropriate input to their children, because sometimes abuse isn't about -- I said previously, it's largely about power, but sometimes it's about not knowing what to do.

So I think education for parents who struggle would be a starting point. But I think, more so, we need to look at our care system and how it's staffed. How the

staff are trained. How they are monitored, because I don't think -- there are people -- I mean, we have seen this across the piece. There are people getting themselves into positions like this, you know, in caring positions, to abuse. And we have talked -- grooming was mentioned and that -- you know, that does happen.

But I think we need to be thinking about how we provide care, who provides it. I think things like how we pay people who provide care needs to be taken into that, because carers are not paid particularly well, which is something about how we think about them and the people that they care for. And I think, as a society, we need to do a bit more there.

So I suppose that's kind of what I'm thinking.

Q. You do expand upon that in your statement, at paragraph 49, by saying:

'People also need to be paid well to do the work that they're doing within the care sector. The sort of pay people get is appalling. People are paid better to work in Lidl than they are to look after people with learning disabilities. If you're not valued, how can we expect you to value the people you're caring for?'

So do you think there's a particular problem to the way that people in those caring positions are treated?

A. I think that we say the right things now and I think

that the ethos or certainly mission statements, et cetera, all say the right things now. But I think what's not happening is, we are not valuing the -- you know, we might say those things. But, if we're paying them minimum wage, what does that say, you know?

And also, the other thing that I have mentioned in there is: when I -- this is a change that I think is probably for the worse rather than for the better. But, when I first started and until, kind of, we moved into using SDS or people getting their own support payments to pay for -- to buy their support, we were able to train staff. Staff would get time to come and be trained, and they would cover the shifts of the people so that the people who received the support would still receive support.

Now, if I want to train somebody, a member of staff from a support organisation, they only get paid the hours that they cover, so that person loses the support for that period of time. That's what happens. And, again, people need training. So what I was saying that: you're not worth enough to be allowed to be trained. Or the person that you care for isn't worth enough to be allowed to be trained and still receive the support they should be getting.

I think that's probably what I'm getting at.

Q. It's almost like allowing staff time out to receive that proper training --

A. Yes.

Q. -- while ensuring that other person is still supported at the same time.

A. Yes, absolutely, uh-huh. Because people get -- you know, you do get payment for inductions, so people will get inducted and -- but your training is for life. When you're working in that sector, things change. People's needs change. Your training needs to be updated, you know.

And just thinking about myself over my own, sort of, career, the amount of training I've done is massive.

Q. I think, just touching on that staffing element again, you do indicate in that paragraph that some people get themselves into these roles and positions to do just that, referencing abuse.

A. Mm-hmm.

Q. But you then say:

'Some of the things that happened are cultural.'

A. Mm-hmm.

Q. Can you expand upon that further?

A. I think when you're working in -- I guess, as an example, if you're working in a residential care home, for example, and there's not an awful lot of oversight

of that, you're left pretty much to your own devices. You're not -- I mean -- and this does happen and has happened in the past. I would hope it doesn't happen as much now or if at all. And you're working with people who are difficult to support. You know, have difficulties that might, you know -- you know, I mentioned earlier in challenging behaviour that people can faecally smear, for example, that's not very pleasant. So people start to dehumanise the folk that they're working with, they don't see them as human beings. The culture starts to slip and become, I suppose, more toxic or just a culture of, kind of -- it becomes almost like bullies and victims. And you come into that as a new member of staff. You may -- that might not be how you want to work, but it's really hard to challenge that if you're the only one.

So cultures can get, you know -- and I'm sure you'll have come across that in this as well. Cultures within services can have an impact on how people are treated.

MS MCMILLAN: One moment, my Lady.

(Pause)

I think that's all the questions I have for you this morning. Thank you very much.

A. Thank you.

LADY SMITH: Gillian, can I add my thanks. It's been so

helpful to hear from you in person, in addition to having your written evidence. I'm really grateful to you coming forward and sharing your thoughts and your own experience.

I'm now able to let you go.

A. Thank you.

LADY SMITH: Enjoy the rest of the sunny day outside.

A. Sunny day, yes. Lovely.

(The witness withdrew)

MS MCMILLAN: My Lady, given the time now, I understand that Ms Innes is going to have a read-in at this opportunity.

LADY SMITH: Let's do that. Yes.

MS MCMILLAN: Thank you, my Lady.

LADY SMITH: Thank you.

MS INNES: My Lady, the statement that I'm going to read in or part of the statement I'm going to read in is that of a witness who remains anonymous and has the pseudonym 'Alex'. His statement is at WIT-1-000000920.

Parts of 'Alex's' statement relevant to the Scottish Prison Service, essentially from page 31 onwards, were read in on Day 393.

'Alex' (read)

MS INNES: 'Alex' was at three institutions covered by this case study: RSNH, Ladyfield and Monken Hadley. He was at RSNH from [redacted] 1969 to [redacted] 1970. He was at

Ladyfield from [redacted] 1971 to [redacted] 1971. We have those dates from the records. In his statement, 'Alex' believes himself to have been at Ladyfield for a longer time.

The records do confirm that he was at both Ladyfield East and Ladyfield West, as he says. The records that we have make no mention insofar as we can see of Monken Hadley, although there is a gap between [redacted] and [redacted] 1976, which would coincide with his memory of having been there for three months, around that time.

By way of introduction, 'Alex' was born in Johnstone near Paisley. His first recollection of school is at Abbotsinch Boys' School in Paisley. From there, he went to the Mary Russell Institute, also in Paisley. Then, at page 10, he tells us that he went to the Royal National Institute in Larbert.

He believes at that time that Barnardo's were still involved in some way in his care.

So picking up at paragraph 42, on page 10:

'It was the head of Mary Russell that decided I should go to Larbert. I had no prior knowledge of it. Two members of staff from Larbert and a welfare officer from Paisley took me. I don't know their names. I kicked off. I wanted to know where I was going. I had

no idea where I was going or where I would end up. I kept asking where I was going and I was told: you're going somewhere nice. You'll see when you get there.

'I was 8 years old when I went to the Royal National Institute. I walked in freely with two members of staff from Larbert. During the journey they were talking. I was silent and wondering what was going on and where I was going. I was given paraldehyde the night before to calm me down and in the morning I was given chlorpromazine.

'I wondered what the place was. It was a red-bricked building with an arched doorway you walked through and tiles on the floor. It looked more of a geriatric place. It was a big massive house. There were four sides with lots of windows. It had lots of grounds.

'There was a big kitchen and dining room. It was the first place I was in that you were allowed out to associate with the people who you were in with. There was a playroom and three classrooms. I was in a dorm with six kids. There were two sides to the building. One was more an adult side for elderly people with psychiatric problems. We mixed with them outside in the grounds.

'There were about 12 to 15 kids there. I think I

was the second youngest there at eight. There was one younger lad. The oldest child was 12 to 14 years old. I have no recollection of any girls being there. There were about three dorms for the boys. I can't remember the names of any of the staff. In the three places I had been in, the only nice people were the cooks and cleaners. They didn't stay in the residences. The staff were in white coats again, like in an institution. It was still under Barnardo's.'

As I've said, that is 'Alex's' understanding of who was running the institution:

'You got up from bed a bit later there. We weren't treated as badly and physically as we were in the other two places [that he had previously been in]. I was still under constant medication under their control, three to four times a day and Prozac at night to help me sleep. I had no control over myself. I couldn't remember the names of these people because of the heavy amount of medication I was on.

'I was put in a room and locked up. They would open a door and say, "There's your breakfast and there's your medication". You got a bit of freedom out in the grounds playing with the other children. It gave me the impression I'd get help there, but when you're under constant medication, you don't know whether you're

coming or going. You're constantly weak and tired.

'I remember the kickings and slappings. If the medication was wearing off, they would try to tell me what to do or they would grab me and hold me and I hated being manhandled, so I would kick off. It happened to others, too.'

At paragraph 50:

'We were taught English and maths. The classes were in age groups. The most in a class would be five or six at a time. I don't feel I got an education. To this day I never went to a primary or secondary school in my life.

'When I was allowed out, I ran off. There was one time I was brought back three times in the one day. I would go to the Thistle Centre, it was like a shopping mall. I was trying to find my way to the train station or somewhere to take me away. The police would take me back. I would tell them what was happening to me, but they never listened. When I returned I was taken into the office and asked why I had ran off. I told them I was sick of being physically abused and medicated. They said I was trying to beat the system but I was just trying to get the system to listen.

'A couple of times I was ghosted, wakened up early in the morning and was told I was going somewhere else.

This is how I ended up in the Crichton Royal, in Dumfries.

'They didn't celebrate Christmas or anyone's birthday. I had no visitors. No social workers came to [visit] me. That was about four years in care and nobody in my family had visited me.

'It was an horrendous place, full of sexual abuse. In the showers I saw things. I saw the fear, the horror, the trauma. I saw a member of staff taking a boy's trousers down and trying to rape him in the shower. I hit him with a fire bucket full of sand.

'Several members of staff tried to abuse some gullible, vulnerable and disabled children. I can't name any of the staff. One was small and fat. He wasn't completely bald. He had hair on his sides. He was leery, creepy and horrible. He happened to always be there at shower time. At first I saw him trying to undress a couple of boys and telling the boys he would help wash them. Both the boys were capable of undressing and washing themselves. I told him he wasn't doing it. The boys were petrified. It wasn't really showers we got. It was a quick strip wash. Him and a couple of others always wanted to help. I saw him getting very gropey, over-friendly, as if he wanted to help to satisfy his wants and needs, pulling their grey

shorts down. I saw the young lad screaming and holding on to his snake belt, not wanting him to take his shorts down.

'The older boys that were there were just turning a blind eye, probably because it had happened to them. I couldn't take any more, so I grabbed a bucket. It was the closest thing to me. I picked it up and hit him. He fell and, when he tried to get up, he banged his head against the wall then fell on to the taps. Someone ran out and said there was a fight and members of staff ran in. He was on the floor, sand all over it. Two members of staff rugby tackled me and were on top of me with my face on the cold tiled floor. They shouted at me, "What's going on?". They were a lot heavier than me, so I started kicking off. I told them what happened and the member of staff I hit with the bucket said he was just helping them undress. I was forcefully given liquid medication and the next thing I knew I was waking up in one of these little cooling down rooms. I was there for hours, for about a day. Then the head of the place came to see me. I don't know his name. He told me the police were coming. I said, "Good, bring them. I want to explain things to them". The police spoke to me about an assault with the sand bucket. This was the first time the police were called because of my

behaviour. They tried to impress the staff by telling me off, giving me abuse and giving me a couple of clouts. They didn't charge me.

'I got into trouble for misbehaving and sometimes for being out of bounds. There were days I spat the medication out. I tried to tell the police and the social worker who came to send me to Ladyfield, in Dumfries, about the medication, but nobody believed me.

'I was sent to the Crichton, in Dumfries, and spent some time in both Ladyfield East and Ladyfield West there. I was sent because of my uncontrollable behaviour and my violence. I went there when I was 10 years old. The police and social services took me. Again, I wasn't given any notice. I was just told I was going.

'I went to the Crichton Royal, which was in Dumfries. I was in Ladyfield East for a year and transferred to Ladyfield West for another year. Ladyfield East was like "One Flew Over the Cuckoo's Nest". There were adults in there. I went there under the Children's Mental Health Act through the social services. It was easier than the first three places. There were boys, girls and adults there. There were different annexes. The place was huge.

'Ladyfield East was more like a hospital. It was

mixed with boys and girls. I can't remember how many were there. It was like an orphanage. There were two younger kids than me and the oldest was about 15. I can't remember staff names. Again, they wore white coats. There was more freedom in Ladyfield West. I was transferred there after a year.

'Ladyfield East was physically brutal. If you looked at the staff the wrong way you were reprimanded or clouted. If you stood up to them and argued back, you were leathered with belts, cat o' nine tails and cricket bats. This was the start of more brutality and psychological abuse. As I was 10 years old, I was standing up to them. In their eyes, I was uncontrollable, violent, a nuisance, a pest and obnoxious.

'We got up at eight o'clock, washed, dressed, had breakfast and then went to classes. Again, we were taught English, maths and RSA. We then went to the dinner hall at lunchtime. The place had a clinical or surgical smell. After lunch we went back to the classes until three o'clock, then we went back to our rooms or went and played in the annexe for half an hour. We then had our dinner and stayed up until eight o'clock. We went to the recreation room. There was a pool table there. Staff supervised us in there. At the weekends

we would clean up our area, tidy our room. We would do other chores, like help out in the kitchen and lay the tables. We didn't go to church. We weren't allowed anywhere outside the grounds. I can't remember any of the staff names.

'You got a shower about twice a week. We had allocated times. There was no privacy as we were always supervised. There was a tin bath and you had to stand in it and have a strip wash. This happened once a week in both Ladyfield East and West.

'We were never taken to a doctor outside the institution. If you were injured, you were treated internally. We were given medication three times a day, every day, after our meals. You were supervised taking it. They made sure you did. I can't recall ever going to a dentist.

'We never got any pocket money, we were never taken on any trips. I never had any visitors. Nobody ever sat me down and asked me how things were going or how I was. No social work, no family, nobody.

'I was still wetting the bed in Ladyfield East and West up until I was about 13 or 14. When you did it, it was treated like it was the crime of the century. You were battered, made to wash your sheets, humiliated by being told you were a pissy bed in front of everybody.

'I was wetting the bed every day in Ladyfield East, so it happened quite a lot. I wet the bed and I wet myself in class because you couldn't ask to go to the toilet and disrupt the class. When this happened I was humiliated and degraded. Other kids were, too. In the last class before lunch you would go down and wash your shorts in cold water with carbolic soap in big square sinks. You then had to go into class in your underpants. It was humiliating. They put plastic sheets on the bed to stop the mattress getting soaked.

'I don't know why I was transferred to Ladyfield West. I saw it as just going to another place because there was a bit of distance between them, even though they were in the same complex. It was easier there, apart from wetting the bed. There wasn't much difference the first three or four months, but after that they would take you out to places in groups. We were sedated with medication before we went and people would see that there was something wrong with you. It was the first time in any place that we were taken out. We were taken a walk ... to the town centre.

'It was my view that I was in a mental asylum for children. I heard a member of staff saying, "He's in an asylum now and it's the only place for him".

'It was the first time I had seen pets, little

animals like hamsters, guinea pigs and rabbits. They kept them there. The difference between Ladyfield West was that I was beginning to accept and realise there was an easier way to do things. Nobody was listening to me, so the performances were wasted. I realised that if I went along with them, it might get easier and I might get changes in my life.

'The food was always the same. It was cooked for you. I wouldn't say it was cuisine, but it was edible. There were no problems if you didn't eat it.

'I ran away several times. It may sound daft, but my last memories of the horrible woman that had called herself my mother was seeing her being beaten up by one of the drunken boyfriends. Even though I didn't like the woman or know her, I ran away to make sure she was safe, even though I hated her, even more so the younger brothers and sisters. I only knew them from when I went a day out with them from when I was at Larbert for about a day. I got out for a day with staff. We went to Stevenson on a beach thing with staff from Larbert. The "thing" wasn't there, but some of my brothers and sisters were. This was my only meeting with them until I was 13.

'There was a few of the staff that were innocent of the physical and emotional abuse, but they were more

guilty of neglect, but with a lot of the staff the way to control us was with physical abuse, beatings and slaps for misbehaving. I can't remember any of the staff names from either Ladyfield East or West.

'From Ladyfield West I went to Merton Hall, in Newton Stewart. I was 12. I was there at least two years. I remember the social worker when I was there. Her name was Liz Maloney. She told me I was going there and came up and got me a month later. There was only me and her in the car.'

Moving on to page 23 and paragraph 100:

'I got moved from Merton Hall because I kept getting into trouble, running away, breaking into places. I think I was seeking attention, but going the wrong way about it. They didn't tell me I was going to Monken Hadley ...

I didn't get any notice. They came and got me and said I was going to somewhere not so far away from Merton Hall that would be easier and better and help me move on with my life. This was in 1974 or 1975. I was taken by a member of staff and one of the people from the local social services. I don't know the name. I presumed it was under a child protection order. I was never consulted. It's about a mile-and-a-half away. The journey took about 20 minutes.

'I hated Monken Hadley immediately, as soon as I walked through the door. There was a member of staff dragging this young kid who was kicking off as I walked through the door with the staff member. I said it was out of order and got pushed into an office.

'I was there about three months. The staff were casually dressed. I don't remember any of their names. It was mixed, with boys and girls, about ten unruly teenagers. This wasn't a Barnardo's home. I'd left them after Larbert.

'I ran away the next day and was caught in Newton Stewart. It gave me the creeps. You could hear kids screaming all the time, echoing round the place. I ran away because I thought there was something wrong with the place. I suffered more violence from the staff. The police brought me back. I told them I was being hit, but they never listened to me. They didn't believe me. When I was brought back I was told off. I was put in a closed block. You were locked up. You weren't allowed out. I got no privileges and I was left in a room on my own. I had no medication.

'I felt I wasn't cared for, protected, respected or looked after. I felt the same as I did in every place. I didn't understand why I was there and also what help they were meant to be giving me.

'Nobody came to see me at Monken Hadley. It was just like the other places I had been in. It was a dirty place. When I wet the bed, they didn't change the sheets and would beat me and slap me. I lay in the wet sheets for a few days before they changed them. You only got to change clothes twice a week if you'd peed the bed. If you didn't pee the bed, it was almost every day you got a change of clothes. We only had two sets of clothes, school clothes and casual clothes, tracksuits, et cetera. The social work supplied the clothes.

'They would discipline you by hitting and grounding you and keeping you in your room. There were a few kickings and beatings to teach me a lesson, to teach me to respect people. I thought I was doing this, but they thought I wasn't. To teach me not to misbehave, not to interfere, to keep me under their control. They would shout at you, right in your face, calling you horrible names, "You will do as you're told", and then slap you. It was what I witnessed, seen and went through behind closed doors. Staff regularly slapping kids, punching kids, dragging them, pulling them by the ear, by the collar.'

'Alex' then goes on to speak of his experiences in Kibble, Thornly Park, and SPS establishments.

Moving to the final page of his statement, on page 45, he says:

'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.'

'Alex' signed his statement on 24 February 2022.

LADY SMITH: Thank you very much.

Well, I think we should stop there for the morning break and we should have another witness ready at quarter to or thereabouts?

MS INNES: Yes.

LADY SMITH: Thank you very much.

(11.25 am)

(A short break)

(11.45 am)

LADY SMITH: Ms Innes.

MS INNES: Thank you, my Lady.

The next witness is Frances Brown, who spent some time during her training at Lennox Castle and now works and set up, in fact, an organisation called Radical Visions.

LADY SMITH: Thank you.

Frances Brown (affirmed)

LADY SMITH: Thank you so much for coming along today to help us with evidence about Lennox Castle. It's really good that you have engaged with us and also provided a written statement in advance to help me understand what particular matters you will be able to speak about.

I have a question for you and I hope it's an easy one: how would you like me to address you?

I'm very happy to use either your first name or your second name?

A. Fran.

LADY SMITH: Fran. Well, Fran, thank you for that. You see, I wouldn't have known Fran and I might have annoyed you calling you Frances.

As we go through your evidence, please don't hesitate to speak up if you have any questions or if you're puzzled as to why we're not asking you something you think you can help with. Feel free to say something about that.

If you need a break at any time, just say. Obviously, I'll stop at 1 o'clock for the lunch break. But I hope we'll have managed to get through your evidence by then. We probably will.

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

A. Thank you.

LADY SMITH: Thank you. Ms Innes.

Questions by Ms Innes

MS INNES: Thank you, my Lady.

Good morning, Fran.

A. Morning.

Q. You have provided a statement to the Inquiry, which is at WIT-1-000001594. And if we can go straight to the final page of that statement, please, at paragraph 247, it says there:

'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 we can see that you signed the statement on 30 April this year, so just last week?

A. Yes.

Q. If we go back to the start of your statement, again, we can see that you were born in 1960 and, at paragraph 2, you tell us that you began training as a registered mental nurse around the time that you turned 21; is that right?

A. That's right.

Q. At paragraph 4, you tell us that, quite early on in that course, you spent eight weeks at Lennox Castle Hospital,

training in learning disability?

A. Yeah, that's right.

Q. You think that must have been around 1982?

A. Yeah, I think so. '81/'82.

Q. Then, going on over the page, you talk about your qualifications and the work that you did thereafter. But, at paragraph 7, you say in the early 1990s, you were promoted to clinical nurse specialist for rehabilitation and your job then was to shut the Woodilee Hospital and help resettle the residents.

A. Mm-hmm.

Q. In that context, I think you came into contact with the Richmond Fellowship?

A. Yeah.

Q. And then, in 1993, they headhunted you to go and work with them as an area manager?

A. Yeah.

Q. Is that right? And you go on to talk about your work with the Richmond Fellowship, at page 3 and paragraph 11.

You talk about going back to work at Lennox Castle. You were working with the first person to come out of there. So am I right in thinking that this was part of the closure programme at Lennox Castle?

A. It was the first person to come out of Lennox Castle

with a very individualised support arrangement. It wasn't the first person to come out of Lennox Castle.

But the work that we'd been doing, in my statement before, paragraph 11, I've described as a consortium of providers and an organisation called SHS, in Scotland, they had got European social fund money at the time and we were learning a lot about how to work differently with people. So we were learning from people, you know, across the world, really. A lot of people from America and Canada about their experiences in person-centred planning. But also, what came from that was a real, kind of, realisation over time that it was much more than that. It was about working very differently with people, because it was about thinking about people, one person at a time, thinking about how to design services around what made sense for that individual person and doing that in a way that was much more the same as you or I would live in the community, not, kind of, in some sort of special -- so, way back then, we were beginning to think: we need to come up with solutions. We know it's wrong but this was part of the solutions that we started to drive as part of the work that we were doing.

So I was still working for the Richmond Fellowship and, through that work that we were doing, we started working with this young woman out at Lennox Castle. But

we did it very differently, rather than her go live with four or five or six other people, we worked with her very individually. She had -- again, you know, somebody that had a reputation for being -- you know, somebody that probably would find it very difficult to live with lots of other people. So everybody was on board with that.

So that was before I went and left Richmond Fellowship to set up or be involved in the setting up at Inclusion Glasgow, which was a new organisation. So it was a very different way for Richmond Fellowship, at that point, to work in. I think it was the first person that came out in that way, lived on her own. She came and interviewed our staff. So we're talking about -- you know, she was sat in with me and helped create her own team around her. And then we supported her to obviously move into her own home with that very individualised team around her.

Q. That would have been, you say at the bottom of the page, about joining Inclusion Glasgow, in 1996?

A. Yeah.

Q. So this first person that you're talking about, that would have been --

A. Maybe '95/early '96. That would have been, that that person would have come out, '95 probably, yeah.

Q. And you also mention in this part of your statement, at paragraph 13, John Dalrymple?
A. Yeah.
Q. And was that when you met John?
A. I met John as we started to get involved in setting up Inclusion Glasgow, a wee bit after John and Simon had obviously met. It was probably more once I was working for Inclusion Glasgow that I met John.

I was actually -- it's not in the statement -- but I was actually working with John's colleague, who was part of the hospital closure programme. We were doing a diploma in community care at Glasgow University together. So Gina Hagan, who is not mentioned there, but she was his colleague. So I knew of John and I knew of their work.

LADY SMITH: So that is somebody called Gina Hagan?
A. Gina Hagan, yes.

I met John after I started working for Inclusion, I think.

MS INNES: Then you go on to talk further in your statement, on page 4, about your work with John. At paragraph 21, ultimately, in 2017, you and John set up an organisation called Radical Visions.
A. Yeah.
Q. And is that an organisation that you still work in

together?

A. Yes, yeah.

Q. And what's the purpose of that organisation?

A. Radical Visions' purpose is to work with people, families, organisations, erm, to do that in a way that is person-centred. We work in advocacy roles and we develop and design services for people. We do that in various partnerships with different organisations.

But our main aim is to ensure that -- I suppose our biggest concern was that institutionalisation, although both John and I had spent many, many years over our careers involved in de-institutionalisation and making sure that places closed and that, you know, there was a real anxiety and fear -- and there continues to be -- that we haven't learned everything that we need to learn and that we continue to redevelop small institutions, continue to grow. People are still encouraged to go and live in group situations or being pushed, because of finances, or whatever into more institutional-types of settings than they would if the money was available. And so we felt there was a real -- particularly at that time and continued, it's got more and more of a challenge, really, as to, kind of, hold on to the learning that we already have made over those years, and to hold on to the idea that we really should be working

one person at a time.

So we have great legislation, self-directed support legislation. A massive part of our role is to help people understand that legislation and to help people, you know, get the benefit of that legislation, people themselves, families, because it does give people, you know, rights to be in control and to be heard, and to make real choices about how they want to live their lives.

So we've got good legislation. A massive part of our role is to try and make sure that that is understood and implemented in whatever way we can.

LADY SMITH: Fran, you say, in paragraph 22, that one of Radical Visions' main projects is something called Advocacy Plus and the purpose of that, as it suggests, is to provide people with advocacy services if they are, as you say, stuck in the system. What kind of things are you finding that they need your help for?

A. People will come to us for a whole range of things. But, certainly, the first person that we worked with under that banner of, kind of, Advocacy Plus was a woman who was -- who was in hospital. She was stuck in hospital. Her brother came to us because this lady had an injury, a fall. She had a history of learning disability and she had a visual impairment. She lived

at home with her family her whole life, so never been in any kind of institution, and she was in a general ward in Glasgow. And her brother had made all the arrangements that he felt necessary, including changing the property and everything to help her come home.

She was 59 and, at that point, everybody was basically -- the clinical team, the social work, in particular, were saying that she needed to go to some kind of long-term residential or nursing home. And he was very clearly saying: 'No, my sister needs to come home and live with her mum, where she belongs and where she has been all these years'. So they got into a real battle and he felt very marginalised, and he found us. And so we supported him through that process of helping him get his sister out of hospital.

We helped him for a long time after that, kind of, try to get the right package of support in, because even although she did come out of hospital, they still wouldn't fund it properly. So he was spending a great deal of his time and couldn't go back to work. So we carried on supporting him over a long period of time with that.

That situation was actually in the public domain because the Mental Welfare Commission, we had got them involved and they picked it up as their annual -- they

do a report once a year. So, several years ago, that was their annual report that they published, was around this story.

LADY SMITH: Thank you. That helps me understand that work.

A. So that -- but it can be all sorts, you know, of different reasons. A lot of it, you know, you'll get a young person maybe will come and say -- another young person we're working with just now, who had came and said to us: 'I want to get self-directed support'.

And he was basically being told, really, that that -- he wouldn't be able to get self-directed support. They might offer him some home care. This is a young man with a degenerative condition. And so our job was really to -- so we would go in that situation -- in both those situations, but in that situation and plan with the person and come up with the service design that makes sense. And then work with the local authority, work with social work and help them see that this is the plan that this person -- makes sense for this person. And actually this would be the cost and this is how to do it. And, quite often, the social worker -- in that case, the social worker was like: 'That's really helpful. That helps me go and make the case in my, you know, department about how to get the right support for this young man'.

And that's -- so he eventually got his budget in place and lives in his own house. So it's those kind of things that we would be involved in. Does that --

LADY SMITH: Yes, it does. That's very helpful.

MS INNES: Do you become involved in discussions with various agencies about transitions for children? For example, a child moving from an institutional setting into a home or community setting, as you've said, or where they're leaving the care system, to put it that way, and moving out of that?

A. Yes, I mean, I think we've been involved with a number of people in that, kind of, stage. We have also been involved where people are even getting stuck through that transition from school, where a family will be saying -- I'm working with one family, where they were very clearly being told there would be no funding for this person to go to college or to get the support to go to college. They just had to go to the day centre that was available. So the role we played there was to get alongside that family, do a planning process, help them think again about what kind of resources it would take for this young person.

It's demonstrating that this is -- the legislation's there, people have the right, and it's being able to demonstrate through that process that their voice is

heard and that this makes sense. And then, obviously, being able to, kind of, be clear about the cost attached to that and how it would work. So that you then can take that forward and the person get -- you know, would get the kind of support that they wanted. And in that, you know, situation, what you're hoping is that they get a budget and that the person can then go out and do sort of things that an 18-year-old would do, like go to college and start to think about work or other things in the future.

So that would be something that we would get involved with as well.

Q. We're going to come back to some of the -- you mentioned in your evidence a moment ago about lessons to be learned from the work that you've done, and we'll come back to that later in your evidence.

I'm going to take you back now to the time that you spent at Lennox Castle. This begins at paragraph 25 of your statement, on the page that we have on the screen.

You spent time there, as you say, as a student nurse. The first four weeks were on a female ward and the second four weeks were in a male ward.

On these wards; do you know if any of the patients were under 18?

A. I don't think they were. But I don't know. I couldn't

say for sure. I think it was an adult female ward, so ...

Q. Then you talk about -- you describe what the ward was like. At paragraph 27, you note that there was no privacy on the ward; can you tell us a bit more about that?

A. My memory was that there was no individualised space for people. There was no wardrobes or drawers or -- there were just beds really, kind of side by side. Even then, I don't remember curtains being round all the beds. Maybe just one or two beds where there was curtains round, so that people could get, kind of, any privacy. If you needed to do anything with somebody in that room, you could use that bed that had curtains.

But I don't remember people having any of their own -- at that time, having any of their own personal belongings, in a way that you or I would, even just to keep your own clothes or anything like that beside your bed. It was just really big, long Victorian wards with the beds in them. Very sparse, very hospital. Even the covers, you know, all of that was, very kind, of hospital issue, bedspreads and -- so nothing was personalised or homely. You know, it was very sparse and not a nice place for people to live.

Q. At the top of the next page, you go on to speak about

your initial impressions of Lennox Castle. At paragraph 29, you say:

"Lennox Castle was a different level in terms of what I saw and what I experienced. It was as if all my awful impressions of Woodilee ...'

Which was a hospital you had worked in before, that your awful impressions of that were intensified.

Can you explain what you mean by that?

A. I think when I went to Woodilee, I mean, it was massively difficult, so I did have a very similar, kind of, experience when I went there as a -- you know, young woman.

I think the difference with Lennox Castle was -- I think the difference for me was it felt much less kind and it was -- certainly it felt noisier. And it just felt as if there was a lot more -- I seen things there that I didn't see in Woodilee. So the environment was difficult in Woodilee, but I didn't see the same aggression and, kind of, er, what felt to me like neglect that I seen when I went to Lennox Castle Hospital.

Q. When you mention aggression; do you mean between the patients or between the staff and patients?

A. I think between the staff and patients. I don't mean aggression as in like -- but just neglect and just not

talking to people and, you know, being abrupt.

Whereas I think in Woodilee many of the same conditions, you know, applied in terms of there was lots of people in small -- you know, small teams of people trying to support them but -- and I remember people working really, really hard to do the very basics in Woodilee, but it was always in -- and that wasn't always good because there were still lots of shortcuts made and stuff. But I always felt it was like people wanted to do their best and you would still do things like people were still looking after people, as in, like, you know, make time do people's hair and put music on, and spend time with people, and I never seen that in Lennox Castle at all. I didn't see people spending time with the people themselves.

I think that was probably -- it was just cold and there was just a lack of humanity. And that -- I mean, obviously, I'd walked into that particular ward and the second ward I was in was a very different experience.

So that ward to me was just like -- I couldn't quite believe -- I couldn't quite believe what I was seeing, you know, I was like -- it was -- I struggled, really, to kind of see -- to check yourself and see is this just -- am I being hypersensitive here?

But I don't think I was being hypersensitive.

I think that was just the reality of how it was, and what I was seeing was real.

Q. We'll come to that in a bit more detail in a moment.

At the bottom of this page, at paragraph 33, you mention that the ratio of staff to residents was actually quite small and you remember that there were around four or five staff to 30 people?

A. Yeah, that's my memory. As I say, it's 45 years ago. And I have been saying, you know, there is bits I think, 'Oh', and I wouldn't have been involved in any of the organising and stuff, so it is very, you know -- but, yeah, I think it was just probably about four or five staff.

Q. If we go to the top of the next page, at paragraph 34, you say, as you have already mentioned, that you didn't work on the children's ward, but you remember going to the children's ward at Lennox Castle?

A. Yeah.

Q. What was your impression of it? Can you remember?

A. Again, this is something I'm thinking -- I think I was taken round when we first started. We got a kind of -- almost like a tour of the hospital, the different wards. And I'm sure we were taken through into the children's ward and, again, it was noisy. It just felt the same, overcrowded. Obviously, you know, kind of a bit

shocking that you've got children, you know, in a ward like that. And then I'm thinking -- since then I keep thinking: did I see that? Did I get shown round there? But I definitely never spent any time in that ward. I didn't -- I wasn't asked to go and do any work in that ward. But I do think I was shown round it and I do remember it. But it's strange, it's kind of a wee bit vague in my memory.

Q. If we go down to the bottom of the page, at paragraph 38, you talk about the culture and atmosphere in the female ward, where you spent the first four weeks?

A. Yeah.

Q. You describe it as being 'punishing', 'punitive' and 'people were scared'?

A. Yeah.

Q. Why was that?

A. Because of, in particular, the SNR [redacted]. The whole culture was created, really, by somebody who ruled by fear. And, erm -- and I think the people who lived there absolutely were frightened that if -- you know, if they -- anything happened, they would be restrained or hurt, or they certainly weren't -- it wasn't a pleasant place for people to be.

One of the people that lived in the ward, I had been

asked to go with to pick them up because they'd been unhappy down at the occupational therapy department and had obviously been upset down there, and the ward had been phoned to go and pick her up. And on the way back up, that person, the whole time, was petrified to go back to the ward, because they were saying they were going to be punished when they get back to the ward.

So, you know, walking up the hill with this person who obviously didn't want to go back into the ward, because they were really -- knew that there'd be consequences because they'd been upset. And, obviously, you know, acted out that upset in the occupational therapy department. But they knew when they got into the ward, or they felt when they got into the ward, that there would be consequences to that.

Q. You mentioned people were scared; does that -- you mentioned a patient there; did that extend to the staff who worked on the ward or not?

A. I think the staff were probably scared as well. I think anybody that -- so I spoke -- when I was seeing some of the things I was seeing, erm, I did speak to -- particularly to some of the other -- there were some other students, but not students in my class, students of Lennox Castle, I'm sure, in the ward at the same time. And I thought, you know, 'That would be somewhere

where it's a good place to have a conversation about: did you just see what's going on? Is this really what's happening?'

And I think people were saying -- you know, I remember people kind of agreeing that they did see it and it was awful, but nobody really was prepared to see or do anything about it, because I was, kind of, saying, 'Well, we need to do something about this'.

And, you know, that just was -- people just felt really kind of frightened.

Q. Okay, and then you mentioned that the SNR [redacted] on this ward, her husband was [redacted] a charge nurse in another ward and you say a lot of families worked at Lennox Castle. What impact did that have on the culture?

A. I think it was a very closed culture, so I think everybody knew everybody else's business and everybody supported each other, in terms of the people, obviously, who worked there.

So there was -- you know, I think, certainly, it didn't feel as if -- if something happened somewhere, everybody else would know about it. And if you were -- certainly my experience was once I had been in a position where kind of I was the whistleblower it was as if everybody -- so many people were just not even

speak to me or would sit beside me in the canteen or look at me. It's as if everybody knew. It just went like wildfire.

So I think there's something about -- obviously, it's quite difficult if you have a culture where you've got so many people that are related and families and people that know each other so well, and something like that, and you're expecting people to stand up and speak, I think it can be quite difficult for people to do that in that kind of environment.

Q. Now, if we go on over the page, you talk about the people -- the people in the wards sitting about and the staff being very detached doing their own thing. Then you go on to say that you started speaking to the residents and, at the end of paragraph 40, you say:

'It's amazing how little people expected and how they responded because they were so deprived of basic human contact and decency.'

A. Yeah.

Q. And was that your impression when you started speaking to some of the patients?

A. My impression was that by just being -- just by talking to people and giving them a bit of time ... and what started to happen was people were gravitating towards me and so it was quite overwhelming to see how open

people -- and forgiving, and just, you know, just so, kind of, open to have that kind of connection with somebody.

And what basically started to happen is, when I came in, in the morning, when I left at night people would come out with me and I would get picked up by my husband. I didn't drive then and he would come and pick me up. And there would be people all standing with me and, like, waiting for me to get my lift, you know. Outside -- sorry, that bit gets me more than anything.

So people would be waiting with me. And then when I came in, in the morning, they would be waiting for me. You know, they would be asking me: 'When are you coming back on?'

Q. So, from that, you're saying, just making that sort of what was a simple human connection --

A. Well, I mean, obviously, I was there for the whole day, so I would be spending time -- but I would be sitting beside people or spending time with them, or if they needed something, I would go and be doing something with them. And it's just, I think, that, to me, showed the lack of what was happening elsewhere, when people are starting to follow you around because you're the only person that's really ... excuse me ... making the connection with them and giving them a bit of your time.

And in some ways, this is the most basic stuff, isn't it? Just that -- you know, the other stuff is terrible, but it's just every day not having -- you know, people were just -- had nothing. You know, just sitting in a room, unless there's something happening like dinner or, you know, bathing or whatever, they're just -- it felt like there was nothing, really, and no connections really for them. No -- but, yeah, so that lives -- that stayed with me, the way that people kind of gravitated, because you were just being normal. Not doing anything what you shouldn't expect to be doing, just having conversations or spending a bit of time, and people just needed it so much.

Q. Do you think the staff on that ward had the time to spend with people?

A. Yeah. There was time. I mean, don't get me wrong, there's always things we can -- but there would be times where they were sitting up in a table with their coffees and chatting and doing all of that, having their breakfasts for ages in the morning, and people would be sitting, you know, absolutely all over the ward doing absolutely nothing. There was no -- the telly would be on in the corner. Many of the people obviously -- would just not even be anywhere near interested in that. There might be one or two people that might be

interested in the TV, but most people wouldn't be. And people were not stimulated and they were bored, and they were agitated because of that, you know.

Obviously, if you have nothing to do, no purpose, nothing to stimulate you, then obviously, quite often, that is going to be a trigger for other things as well.

So, even then, people kind of living with each other becomes more and more difficult, doesn't it?

Because ...

Q. Later on in your statement you talk about some incidents that were perhaps triggered because people didn't have anything else to do, so there might be some conflict or sort of trying to sort of be a nuisance to someone to --

A. Sometimes that's -- it's -- sometimes any stimulation is better than no stimulation. So, even people being -- it's not an unusual thing, that even people being -- if you're so invisible then, even if it's negative, that connection feels better than being ignored. So sometimes -- I mean, and it's the same when people maybe self-harm, hurt themselves, bang their heads, these are often stimulation, people needing to get some kind of stimulation, some kind of effect. And sometimes when folk, you know, challenge, you know, each other as people that live together, but also the staff, again, it's better to have some kind of interaction. Sometimes

people, you know -- if you think about it, that's maybe the only time they're being seen, the only time they're being touched, you know, in a way, sometimes they're being held if they're being restrained. So there's all of those things, I think, that although it doesn't make any logical sense to us or it wouldn't make logical sense to them, but I think it feels better than just being ignored.

Q. At paragraph 41, you say that the male ward was an absolute contrast to the female ward; what made the difference between the two wards?

A. It was just a completely different environment. And I think it was a culture that had been created in that ward and the rules were obviously set by the -- the culture was set by the person who was running that ward, which was a man. And he -- the people around him, he was kind, he was thoughtful. And it just was a completely different atmosphere and environment in that ward. It just was, like, completely different. You could have been in a different hospital, actually.

And obviously I was, kind of -- I think that because of the issues that I'd raised in the first four weeks and being in that ward and being a whistleblower, then I had been sent to this other ward deliberately. I think there was kind of -- that's my memory of it.

I don't know whether that's true or not. But it felt to me it was almost like they'd been very thoughtful about where they would send me next, because they didn't want, obviously, me continuing to be a whistleblower.

So for me that's bizarre, isn't it? If you know that ward there is where, you know, people will behave very differently and people will be kind and it will be -- it's almost kind of -- and you know that the people in these different roles obviously know what's going on, because they're able to send you to a ward where actually it looks very, very different than it did in that other place, that other ward.

But very much -- from the -- and that, in fact, both of those situations, it came from the people that were running the ward. I'm sure that wasn't the only place it was coming from, but it was certainly set by them. They were such completely different people and completely different characters and they set the tone completely.

Q. If we move on to page 9, please, and paragraph 48, you talk about residents helping one another and you say some people were treated as helpers and carers and they would assist others. You say that you don't think it was necessarily a bad thing?

A. I suppose in those situations, as I say, where people

were -- had very little to do, they -- one of the things, when they were able to care for each other, they had real bonds and relationships as well and they did care for each other. And I know that as years went on and I worked with people later on, when I came back through working at Inclusion, people talked a lot in a really positive way about that, people that were more able, about the fact that they helped other people when they lived there and the kind of roles that they had.

So I think for them it became really, really important that they had those relationships and those roles, and they helped some of the people there that needed more help.

Q. In the next paragraph, you say:

'There was no guidance given on any individual communication needs ...'

A. No.

Q. The residents that you worked with; did they all have different communication needs?

A. Yeah. Absolutely, yeah. A complete variety. But I don't remember anything to do with communication at that time in my training at all. It was like ... no.

Q. If we can move on a little in your statement now, please, to page 14. At paragraph 73, you talk about -- I think you are being asked there about the use of

sedatives, and you can't comment on that in relation to Lennox Castle. But the last sentence of that paragraph, you say:

'Major tranquilisers were regularly prescribed in an ongoing way at that time for managing behaviour.'

A. Yeah.

Q. Is that what your experience was at the time?

A. Yeah, absolutely.

Q. And when you say 'major tranquilisers' what sort of things do you mean?

A. Thioridazine, procyclidine -- is that right? Thioridazine -- you can't have -- er -- sorry, I can't remember the name of it. It's not procyclidine -- I can't remember. It's gone from my head. It might come back in a minute.

Thioridazine was one of them. There was another one which was similar to that, which had different types of side effects. One had more or different side effects to the other, but they were the main, major tranquilisers that I remember being used at the time to manage people's behaviour.

I know that there was also -- paraldehyde was used just at the -- towards the end of my kind of -- you know, I think it was towards the end of it being used, when I was at that stage just coming in. But I do

remember, again, both in Lennox Castle and sometimes in Woodilee it being used, which -- and it was obviously a much more dangerous, kind of, drug to administer. You needed a glass syringe and, you know, it would burn your skin, so I remember that being a real difficult one. But I know that the major tranquilisers were used both regularly and as PRNs.

Q. So as required?

A. As required, yeah.

Q. And when you talk about managing behaviour; what sort of behaviour was it being used to manage?

A. That would be where people were, obviously -- if they were being challenging, if they were seen as being challenging, then it would be used to manage that. I think a lot of the time when it was given regularly, it would be to manage people's -- certainly in Woodilee, it would be seen to be managing people's psychiatric situations. But I think a lot of the time, it was just to keep -- well, in my mind, a lot of the time it was just to help keep everybody kind of quiet. And if you give people those major tranquilisers regularly, then obviously it's going to have that effect.

Many of the people, in both Woodilee and Lennox Castle, would have been there for years. You know, it's not like they were in the middle of some kind

of acute situation where they needed -- that needed to be managed in that way.

So these tranquilisers were just given out. I mean, that was just part of the daily medication that people got every day. And then if something happened on top of that, then you might be asked if you wanted your PRN or, you know if you were shouting at somebody or whatever or -- and then if it got into a more difficult situation and you were being restrained, then it would be intramuscularly that you would probably be given that PRN for that time.

Q. If we can move on to page 17 of your statement, you talk there about restraint, so physical restraint. And did you receive any training in relation to the use of physical restraint?

A. No. The training I got -- which is bizarre, but the training that I did get, when I started at Woodilee Hospital, we were shown a video. And it was a video of some -- I remember -- that's bizarre, isn't it, but I remember the video, it was a guy who was wanting to go home and his medication hadn't turned up yet and he was getting really agitated, so became very upset, and seven people turned up and restrained him. And, kind of, in this video you get shown, you know, lie over a limb, kind of thing. And that was the only training that

I ever had, as a psychiatric nurse, erm, in control and restraint, which is crazy, really.

Q. In this video, you are saying there were seven people and I think the term you used was 'lie over a limb'?

A. Yeah, so people would come and they would be, in this video, saying, you know, so and so comes and lies over this part of the -- but it was a video and, at that time, I wasn't even -- I don't even think I was a student. I think it was a time that -- pre-student. So it was like a nursing assistant role and that's what I was shown. But I don't ever remember being given any further training in control and restraint, even through my student -- and I know that, you know, as I say, through the rest of my career I never ever had any -- I mean, certainly as an organisation, we did train people. But, by that time, I was -- I never went and had that kind of training. I got through my whole career without it, so I decided that I would manage, probably, the rest of it without ever needing to do that training, so ...

But our staff, obviously, it's part of the work that we did. We had to have appropriate support for the staff in place and they had to have right training to work with people.

Q. Going back to the time that you were at Lennox Castle or at Woodilee; did you see people being physically

restrained?

A. Yeah.

Q. And what was the technique? The technique that you had seen in the video?

A. Just, yeah, people probably getting in and doing their best to help, you know, keep the person in one place really. And usually then somebody would be getting an injection and they would be injected, and the person would then continue to be held until they were calm and then they would maybe get up at that point. They might be encouraged to go and have a lie down or whatever, but -- and that could take quite a long time. You know, for some people -- that whole process would be different for different people. But very, very upsetting for people, obviously, to be treated in that way and that was just the normal, you know. So people became very -- you know, as we started to work with people coming out of Lennox Castle, it was almost like we had to really help people unlearn that. You know, that, 'We will behave differently'. You know, 'We do not need to do this. This is something that we can completely change'.

But people were really so used to it that they -- it was almost -- it was quite difficult, really, for them to kind of not expect that the people around them were going to behave in that way if something happened or

something was difficult. So they often were completely heightened. You know, if something happened or if they lost their temper about something or broke something, or kicked at something, that something terrible was going to happen. And it just took time for us to really help people realise: no, actually, what we're going to do is we're going to go over here and give you some space. And then we're going to check in with you and, you know, and see if you're okay after a bit. And then we're going to come back in and we're just going to talk about it, if you feel like it and, if not, you know -- so we had to really re-educate people, really, about -- you know, 'We're not going to behave like this and that means you don't need to do this stuff', and that's really, you know -- that was really quite transformational.

And some of the things that would happen was that people stopped hitting the folk that were around them, but they would still maybe -- they'd still take -- if they were upset and angry, they would still take that out on the furniture or whatever, and people would come and say, 'They've broke that', and I'd say, 'That's great, that's great, that's fine'. It means that we care enough about you and your relationship with them that they know that they don't want to hit out at you

and we work round, you know, what we do with the furniture, or whatever. But it was such a massive step forward for people, when they stopped feeling that they needed to hit out at the staff and that they cared about the staff in a way that they then realised: 'Well, actually, if I'm really angry, I could just break that, you know, or I could throw something around the kitchen. It's not going to be the end of the world', and then we would deal with that.

So, yeah, it was an unlearning of that behaviour. But people were -- it just was a day-to-day thing in both of those hospitals. But, certainly, I know in Woodilee, it was as well. When I worked in the locked wards there. It was -- yeah.

Q. If we can move on to page 18 now, this is where you are talking about some incidents that you witnessed when you were at Lennox Castle.

At paragraph 96, you talk about a lady having been injected with a major tranquiliser?

A. Chlorpromazine. There's the name, it came back to me. Sorry, Largactil is the other name for it yeah, the major tranquiliser. Sorry.

LADY SMITH: That's all right, don't worry.

MS INNES: That's what I wondered: if those were the ones, the main ones that you had seen used at the time?

A. Yeah.
Q. And you talk about a lady having been restrained. You think that she had been potentially given some kind of tranquiliser and then you saw the SNR repeatedly slapping the lady across the head and you couldn't believe what you were seeing. Did you say anything at that point or not?
A. I think -- I think I just came on shift and it was actually -- it was like this was happening as I'd came on shift and I'd came into the dormitory. So it was like the person was in the process of restraining her and then I seen it and I kind of said: 'What's going on here?'

And I don't remember saying anything else or doing anything else. I just remember, like -- there was a bit of me kind of thinking -- you actually think you're not really seeing it. You know, that you're, kind of, checking that you are seeing it. But I just, kind of -- I think that was all I said: 'What's happening here? What's going on here?'

But then I'd just turned up.
Q. Then, in the next paragraph, you mention the incident that you referred to earlier in your evidence, where the lady was afraid to go back to the ward.
A. Yeah.

Q. Then at paragraph 99, you talk about another occasion where a lady was sitting in the corridor crying and upset and you saw that she'd been incontinent. You were wanting to give her a bath and she was suggesting that it wasn't allowed and that was confirmed by the nursing staff on duty?

A. Yeah.

Q. Then you say that you went ahead and did the bath anyway?

A. Mm-hmm.

Q. Then, at the top of the next page, you say, at paragraph 102, that again you saw the same SNR repeatedly kicking a lady with a physical disability, a mobility issue, along the corridor?

A. Yeah.

Q. Now, you then go on to talk about your experience of reporting what was going on in that ward.

A. Mm-hmm.

Q. And at paragraph 105, you talk about going to the school of nursing at Lennox Castle?

A. Yeah.

Q. So I think maybe initially, having thought about it for a bit, you then went to the school of nursing; is that right?

A. Yeah. I think I was like, as I say, I maybe spoke to

a few people in the ward, saying: 'Did you just see that? What we doing about that?'

And then I went down and spoke to the people at school of nursing, which is, as a student nurse, the place that you expect -- you're supported through the school of nursing. You know, you're there, you're in a placement from your school of nursing to their school of nursing, so you expect that that's where you would be supported. So I thought probably that's a good place to go and tell them what I'm seeing and have a conversation about what I should be doing -- what to do about it, really.

Q. And did you feel that your report was taken seriously and acted upon?

A. I don't recollect exactly what happened. I mean, it's 45 years ago, so please do forgive me for not having -- and it's a long time since I've thought about a lot of this.

But I do know that I went there and had the conversation, and it was almost like I was told: 'Right, we'll, kind of, deal with this. Don't worry about it. Just go back to the ward'.

That's the kind of message that I was given: 'Just you go back to the ward. Right, okay, that's awful. We'll deal with it', kind of thing, and that was it.

Q. If we go on over the page; what was the reaction when you went back to the ward?

A. Well, when I went back to the ward, there was an -- it felt to me that there was a completely different atmosphere in the ward towards me. So everybody was very frosty. Nobody was speaking to me. But also the behaviour -- the things that I'd seen and the kind of behaviour towards people was different as well. So I never seen any more aggression like that towards any of the individuals. It didn't change the kind of lack of basic day-to-day humanity, I mean, didn't change or -- but I didn't hear any kind of aggressive shouting or see any other abuse.

So it was a very -- I felt it was really kind of strange for me because then suddenly I, kind of, didn't know -- I felt as if they'd been in touch or they must have known that I'd -- they never said that to me. I've never been -- I wasn't informed by them that that's what they're going to do. But it definitely felt to me that that's what had happened; that they'd been informed, that they knew I'd been down to the school of nursing and had that conversation with them. They'd probably been on the phone right away, saying: 'We've got this woman down here'.

And I think that's what certainly seemed to make the

difference by the time I got back up to the ward. Yeah, things were all that instantly different.

Q. You then go on to say, at paragraph 109, that you were given an assessment by the SNR and you decided to write on the assessment document about the things that had happened?

A. Yeah.

Q. And why did you decide to write that down on the assessment document?

A. Once I went back -- I mean, I'd gone to the school of nursing, obviously, looking for some advice about what to do about what I'd seen. I didn't -- I still was sitting with all of that and I'd obviously -- although things changed when I went back to the ward, I couldn't unsee this. And I couldn't -- and I was kind of in my head thinking: what do I do about this now?

But I knew that my assessment is an official document, so I'd made a decision, really, you know, that once I would get the assessment, I would write my experience of that placement and the details of what I'd seen, because I felt they couldn't ignore it, because it was an official document. It would go back through into the school and go back through into the system and they couldn't ignore what I'd written on it.

So I wrote about those three incidents, even

although it had been at the beginning and, you know -- yeah. So it was my way of making a written statement that wouldn't be ignored.

Q. Then, at the bottom of the page, you say what then happened as a result of this, and the police became involved and there was an investigation. The SNR SNR was suspended and you spoke to the police then?

A. Yeah.

Q. You, I think by this time, were also moved to the male ward, as you've said?

A. That was the end of the four-week placement anyway. That's why I was getting the assessment. But, again, 'This is where you're going to go next', to the other ward that I described earlier, which was a very different ward.

So I don't know whether that was where I was supposed to be going or whether they changed that. There's something in my mind about that that I was particularly sent there because of all of this, to a very different type of ward.

Q. Then, at the top of the next page, you talk about the man who was in charge of that ward, who you have already mentioned, and the rest of the staff on that ward were fine. But you say:

'The whole of the hospital knew that I was

a whistleblower and many people wouldn't speak to me, even my own colleagues wouldn't sit with me in the canteen.'

A. Yeah.

Q. Do you mean the colleagues from the new ward?

A. No, I mean even my colleagues from Woodilee. Even my fellow students wouldn't sit with me when they came in to the canteen because obviously I was like -- I was the whistleblower and that was just -- I was being -- yeah.

LADY SMITH: And this is early 1980s?

A. Yeah.

LADY SMITH: 1982?

A. Sorry?

LADY SMITH: 1982.

A. Yep.

MS INNES: Then, at paragraph 114, you say that the outcome of the investigation, you were told that not one person had supported you or corroborated what had happened.

A. Yeah. In my statements, obviously, in each of those statements -- and I don't remember people's names now -- but I was able to say who was in the room, who else was there, you know, that other people had witnessed the same things as me for the bits that I'd -- so there were other people that I'd obviously named as being able to corroborate what I had seen. But obviously all of those

people were interviewed and none of them said that they'd seen any of the things that I'd seen, so ...

Q. How did you feel about that outcome?

A. I was raging, quite frankly. And upset.

I mean, I'm sitting here now talking about this and it's such a long time ago, but at the time it was massive. You know, the whole experience was traumatic. It was -- I was young. My mental health, I think, was really, you know, affected by it at the time. You know, it was like: what do you do? You are seeing this terrible stuff; what do you do about it?

Then when you do do something about it you're treated like -- yeah, you know, it's a bullying tactic, isn't it, let's be honest about it, by a collective community, you know, that you're being treated really badly.

Then, obviously, on the day that he called me -- they had the office at the top of the hospital and the male part of the hospital was at the bottom. So I had to go up to his office and I remember -- I remember -- I say in here 'losing it', but I remember saying to this man: 'You know, I've done what I can. You know, I've done everything I can. What are you doing?', I said, 'How do you sleep at night?'

I remember getting up and I was having this kind

of -- almost ranting at this man, who was obviously quite a powerful person and I was a wee student nurse. But I just kind of -- I did. I was really angry and I'd lost it. But I was also really upset, thinking: is this really -- is this really -- you're just going to let this stuff go on? You obviously know.

Then he did say to me -- and I think I've written it, it's in the statement there, that he then said to me: 'The only thing I can say to you is that your statement is far too detailed to be a lie'. So it was almost like saying: I know you didn't lie about this, but there's nothing we can do about it, kind of thing.

So ...

Q. If we move on to page 23 of your statement, and paragraph 129, you are talking here about Woodilee and your work there. But I want to pick up on something that you say at paragraph 129, which is:

'People are only limited in these institutions by the institutions themselves. They're not limited by their own abilities.'

Can you explain what you mean by that?

A. So, in the institutions, obviously, people live their lives to routine. Many of the day-to-day stuff that you and I might do for ourselves are done for them, like, you know, obviously cooking and, you know -- but what

you find is the people who were living there, certainly in Woodilee, part of the -- it was a hospital of various groups of people who lived in Woodilee.

There was an acute part of Woodilee, which was your admission wards where people would be coming in and out, maybe with acute mental health issues that needed to be addressed. But there was also two other bits. One was over 65s, a massive increase in people at that age starting to suffer from dementia, so there would be some wards there for people to be admitted. But there was also some longer stay wards where people lived there, really, with dementia.

Then there was these other long-stay wards, where people had came in maybe through the system and never gone away, never gone home, never gone anywhere else. So you'd go into these wards where people were living and they knew what time to get up in the morning themselves. They would make their bed, they would get organised, they would come and line up for their food. And then they would go and they would get organised and go to their work, whatever they seen as their work. If it was a day opportunity or whatever, they would go and do that.

Then they would come back, they would line up for their medication. So they were only ever -- they were

in control. They knew exactly what the next part of their day would be. But they were limited by the fact that they were never able to then make their dinner or, you know, pick their own clothes, or go to that next level. The institution didn't allow them to do that. But you could see the level of independence. These folk absolutely knew what the next step in their day was, and if they'd just support them to learn other things that had been taken and stripped away from them, then they could have been as independent. It just did not make sense that they were in that institution. It did not make any sense.

And in those wards, often, you maybe had one or two people, staff members. You know, you'd have people kind of just living their day-to-day life like that in this routine, day in day out, and limited only by the institution.

I don't know if that's helpful.

Q. Thank you.

If we can move on, please, to page 28 and paragraph 155. You talk about leaving Lennox Castle and you have mentioned already in your evidence that you felt like your mental health was adversely affected by your time there.

Even when you went back, you had a reaction to going

back to Lennox Castle.

At paragraph 156, you say:

'I never saw any of the physical stuff that I had as a student nurse, but I still felt the lack of humanity. I still felt the lack of respect for people and the lack of belief in people. That was a constant.'

A. Yeah.

Q. So these things remained, even when you went back later on?

A. Absolutely, absolutely. It was: why would you think this person would want to live out in the community? Why do you think this person would be able to live in their own home? No, that doesn't make any sense. It won't work. There's no way. They'll be back in a week.

You know, and as people did leave, once we started working with people, they'd get their worldly belongings in a black, plastic bag as they left, you know. The lack of kind of -- still, you know, didn't even have a suitcase, you know, to put their stuff in or -- it felt very, very similar in terms of that lack of humanity, still, for many of the people.

Q. I'd like to move on to the end of your statement and to aspects about lessons to be learned that I said I would come back to.

If we can move, please, to page 40, and

paragraph 230. You say:

'I think any institution can create an environment in which abuse can flourish.'

Can you explain that, please?

A. Well, I think the issue is systemic. An institution, it is an approach. It doesn't need to be a massive institution with 1,200 people to be an institution. So anywhere where you start to group people together, where people are not at the centre and where they're not -- where we don't work one person at a time, I think can create that environment where you just create smaller mini-institutions.

I mean, a lot of the time as we shut these hospitals, we trans-institutionalise people into smaller institutions and we continue to talk and hear of -- we are going to -- you know, we're going to build a new 12-person accommodation for those people who are really challenging, or for, you know, that other group of people and, again, all of these where people are brought together because of a label. None of this is -- none of that way of working is going to help people get a real life and it creates opportunities where that power dynamic is just completely off balance and just continues to develop opportunities where people can be vulnerable and lost, I think, in those institutions.

They're not at the centre of them. Even small group homes, you know, how people then get, you know, decisions made about how they spend their day can depend on how many staff there are and whether or not you can get out today because, you know, somebody else needs to get out and there isn't enough staff. All of those things start to create those opportunities where people feel -- those places where people don't feel that they're able to get their voice heard, the life they want and creates that power and difference, I think, in terms of the staff.

I don't know if I explained that well but ...

Q. You go on to explain that over the page, in the next part of your statement, at paragraph 234, for example:

'Any institutional living environment doesn't work for anybody and certainly wouldn't work for children. I don't necessarily understand why it brings out the worst in people. But there is something about institutional living that creates an imbalance in power. An institution brings out the worst in some people, dehumanises others and creates opportunities for cruelty and abuse.'

I think that reflects some of the topics that you have just mentioned.

A. We've seen it happen so many times, continuing to

happen. I mean, we're talking about 1980s there and 1990s, but we're still, in the public domain, hearing of places where there's abuse happening now. And Winterbourne View and other places where we continue to create those small institutions.

So I think the experience we've had and the work that we did was that we -- through the work of Inclusion Glasgow and other organisations across Scotland have continued to do this work as well, is to work one person at a time. And when you do that -- we did that with all of the folk that came out of Lennox Castle. We were given the same resources as the people who were given the same resources per person that grouped people together. We worked one person at a time. We were able to work with those people to work out, you know, who had people around them or could be more independent over time, who needed more support, and we were able to use those resources in a way that was actually about each individual.

We helped people live in ordinary housing. We helped people buy housing. We helped people go back and live with their families, where they wanted to do that.

We worked very, very differently. We proved through that process that in most of the people that came from -- to Inclusion Glasgow, because of the very

individualised way we were working, came to Inclusion Glasgow because they were already seen to be challenging in terms of within the system or within the institutions. So they were already the freedom fighters, saying: 'No, I'm not going to live with these other folk for another 10 or 20 years'.

And they were telling people through -- people that were involved in the assessment process, or whatever, very clearly that they didn't want that.

So those were the people that came to us. Those people were -- you know, came with, you know, complications and issues and trauma that needed support and we needed to help them through that process. But we managed to do that really, really well and continued to do it in organisations like C-Change, Partners for Inclusion, other organisations. Like ENABLE, Richmond, all continued to start to work more individually and proved that that is the way to work. One person at a time, not grouping people together, because they've got a label of disability, and organising your support in a way because it's a service, not because it's something around what makes sense for that person.

Q. If we go on over the page, linked to that, at paragraph 240, you talk about if you have people living in a smaller setting, perhaps on their own, with staff

around them, then it might be said that that person is more at risk because there are fewer people around.

A. Yeah.

Q. What is your experience of that?

A. Our experience of that is the exact opposite. That because you have created the opportunity to have -- for people who are supported to develop meaningful relationships with the people who support them, meaningful relationships with the organisation, with families, with neighbours, then people are not invisible anymore.

And actually what we found is, certainly if we had, you know -- because you can't completely eliminate the risk that somebody won't come into your organisation that intends to do bad -- a predator or somebody who intends to abuse somebody financially, or whatever the issues are, you can't completely eliminate that.

But what we found was, because of those relationships, we found people were willing to stand up very, very quickly and say: 'There's something not right here.'

They know the person really well. They care about the person in a different way. So immediately you would have staff saying: 'There's something not right. Something not right. There's letters coming here that

shouldn't be coming', maybe it's for a member of staff, or you'd have a neighbour -- these are all real situations -- where you had neighbours phoning in saying, 'I heard shouting next door. I'm really concerned what's going on next door if you've got shouting', you know.

And it might be that it's the person themselves maybe upset or shouting. But it might not be and, actually, they're alerting you, as somebody that cares about that person. So we found that actually it keeps people safe because the relationships are the things that keep people safe. People not being invisible and people caring -- really caring enough, then you don't get the same fear and anxiety. People will speak up really quickly and will whistleblow in those situations and let you know that something's not right for the person because the colleague is not that important, the person is. And that's the way that you allow it to develop and create that opportunity for the person to be the most important person in that.

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

LADY SMITH: Fran, can I add my thanks. Your evidence, both written and oral, has been rich in so much detail that's assisted my learning and understanding of your

background, working not just in Lennox Castle, but wider than that.

I'm really grateful to you and I'm able to let you go now.

A. Thank you.

(The witness withdrew)

LADY SMITH: It's now 1 o'clock. I'll stop for the lunch break and sit again at 2.00.

(1.00 pm)

(The luncheon adjournment)

(2.00 pm)

LADY SMITH: Good afternoon. Ms Innes, we have a witness ready?

MS INNES: We do, my Lady.

Next witness is John Dalrymple, who we have already heard of. He headed up the commissioners at Lennox Castle Hospital, spoken about by Sam Smith last week. And he also co-founded Radical Visions, who we heard about this morning.

LADY SMITH: Yes. Thank you.

John Dalrymple (sworn)

LADY SMITH: Thank you so much for coming along this afternoon to help us with your evidence in relation to this aspect of our current case study, in particular your work with Lennox Castle, a wee while ago now,

I think.

A. Yes.

LADY SMITH: I have a question for you: how would you like me to address you, your first or your second name? I'm happy to use either.

A. John, yeah. First name.

LADY SMITH: Thank you for that, John.

John, if you have any questions for us as we go through your evidence, please do speak up. Or if you think that we should be asking you something that we haven't asked you, make sure we know that as well.

A. Okay.

LADY SMITH: So far as timing is concerned, if we're still taking your evidence at about 3 o'clock, I would usually have a brief pause in the afternoon at that point. But if you need a break at any other time, don't hesitate to tell me --

A. Okay.

LADY SMITH: -- that's fine by me.

If you're ready, I'll hand over to Ms Innes and she'll take it from there.

Ms Innes.

Questions by Ms Innes

MS INNES: Thank you, my Lady.

Good afternoon, John.

A. Good afternoon.
Q. We know that you signed a statement for the Inquiry, it's reference WIT-1-000001590. And if I could ask you, please, to look at the bottom of the second-last page of this statement at paragraph 152, we see there that it says:

'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.'

Then we see that you signed your statement on 24 April of this year; is that right?
A. Yes.
Q. Taking you back to the start of your statement, you tell us that you were born in 1953 and then you go on to explain that your initial degree was in literature.
A. Yes.
Q. But you then became a social work trainee with Glasgow Corporation, as it then was, shortly before regionalisation.
A. Yeah.
Q. You then undertook a diploma in social work?
A. Yeah.
Q. Which was a year-long course?
A. It was a part-time course over the course of a year,

yeah.

Q. And then you took a post graduate certificate of qualification in social work at Edinburgh University?

A. Yeah, that's correct.

Q. And you then go on to talk about the work that you did as a social worker and the various places that you worked.

You tell us that there came a point where you were working with an organisation called Partnership Housing. This is on page 2, at paragraph 7. You say that, at that point, you left your previous job and you became the first employee for a third-sector organisation called Partnership Housing?

A. Yeah.

Q. It was an organisation involved in helping people to leave Ladysbridge Hospital in Banff and Woodlands Hospital in Aberdeen?

A. Yeah.

Q. What kind of hospitals were those?

A. These were both -- I think the term would be learning disability hospitals, not psychiatric. I think that's the wrong terminology. But learning disability hospitals.

Q. Had some people in those hospitals been there for a long time?

A. Particularly Ladysbridge. Woodlands was a newer creation and so I think the length of time that people had been there was generally shorter. Ladysbridge had been around -- I couldn't say from when. But certainly probably from the fifties/sixties onwards.

Q. Had any people been there as children, do you know, or not?

A. Just as we were speaking there, my memory suggested that maybe some of the people in Woodlands had gone in as children and perhaps it had been created as a children's facility in the first place.

It's likely that some of the Ladysbridge people, the older people in Ladysbridge, had also been admitted there as children, yeah.

Q. What was the organisation's role in helping people to leave those hospitals?

A. So we were the support provider organisation. We would recruit the staff to work with people to support people in their accommodation.

Q. And then, if we go on over the page, at page 3, and paragraph 10, you say that you were at Partnership Housing until 1992, at which point you became the Principal Social Worker for Learning Disabilities for the Strathclyde Region?

A. Yeah.

Q. Within that role, you then became involved in discussion, perhaps, initially about the future of the long-stay hospitals?

A. Yeah. So in each of those health board areas, there were four health board areas within Strathclyde, so there were joint planning structures established, you know, across the board. So my involvement in those structures was related to the joint planning for people with learning disabilities.

Q. Okay.

A. And obviously some of them were in hospitals within those health board areas.

Q. And was the planning, for the people who were in hospitals, for them to move out of hospital at that stage or was that something that came a wee bit later?

A. 1992. I think the underlying assumption would have been that most people would be better served by moving on from those institutions. So I wouldn't have said definitely that there was a consensus about closure of the hospitals within those discussions, but that was the direction of travel.

And, obviously, some of the joint planning work was related to the fact that resources which were then in the health service would be transferring to the local authority, so the financial considerations around all

that.

Q. At the end of paragraph 10, you tell us about, obviously, in 1995, Strathclyde -- there was disaggregation?

A. Yeah.

Q. You say that people were being redeployed as a result of that. And you were then sent to head up the closure programme at Lennox Castle Hospital from a social work point of view?

A. Yeah.

Q. Now, we have heard the term 'commissioners' at Lennox Castle Hospital?

A. Mm-hmm.

Q. Were you one of the commissioners?

A. No, I was the project manager. So, within my remit, or within the scope of my responsibility, were the people who worked on the assessment task and the people who worked on the commissioning task. They all were employed by social work, as I was. So there was those dual aspects to it.

Q. So you were heading up both of those teams?

A. Yeah. Ultimately, it led to the commissioning of social care services, so in that sense, it's -- yeah.

Q. Then you go on to say that you worked on that project until you left -- until 1998, when the first half of

that project was complete?

A. Yeah.

Q. Thereafter, you set up an organisation called Support for Ordinary Living?

A. Yeah.

Q. And you were there for about ten years?

A. Yes.

Q. And then over the page, you talk about moving on to another organisation called Neighbourhood Networks.

Then, in paragraph 14, in 2017, you and your colleague, I think, Frances Brown, set up Radical Visions?

A. That's right. That's correct, yeah.

Q. You're still involved in that --

A. Yes, yeah.

Q. -- today?

At paragraph 15, you talk about different models of disability. You talk about the medical model of disability dominating in the early days and then that changing to the social model?

A. Yeah.

Q. Can you explain a little bit more about that, please?

A. So the medical model has, as its basic assumption, that there's something wrong with the individual person that needs to be fixed or treated or cured, locates -- or the

issue within the person, the social model would locate the issues for people with disabilities in society, and most of the issues that people face are to do with other people's attitudes, policies, practices, towards them, and also the kind of built environment and how difficult that is to navigate.

So, yeah, so: 'It's not my problem, the disability; it's your problem, society, that you don't accommodate me. You don't think highly of me. You don't -- you're not well disposed towards me'.

Q. Okay, and then you talk about, in the same paragraph, about de-institutionalisation and you say that it was in conjunction with, but at times in opposition to the NHS; why do you say that?

A. I think the institutions were within -- these larger institutions that we're talking about, these hospitals, they were within the NHS domain, so there was that sense of ownership: 'These are ours. We've operated these for a long time. They're not that bad', would be the kind of underlying assumption there.

I think there was also -- there was a loss of income, loss of funding. It was going to go to the local authorities.

I think often the issues were more about those sort of political -- with a small P -- issues rather than

what is best for people, the conflicts. So I suppose the conflict was about change. It was quite a massive change that was being proposed, ultimately, that these 14 institutions should close and the resources associated with them should all move to the community, and the people themselves should be able to make that move. So I think you always get resistance to that kind of change.

Q. In the same paragraph, you say they weren't really hospitals; what do you mean by that?

A. Well, I mean, if you and I go to hospital, we're expecting some sort of treatment for an illness, a medical condition. That wasn't happening. These were places where people were housed, accommodated, warehoused. The -- there were psychiatrists employed there, but there was very little psychiatric treatment going on. And I think that I say elsewhere that the basic physical healthcare that you would expect to get via your GP, even that standard of healthcare wasn't being provided within something that ostensibly was a hospital.

Q. Okay. If we can move on a little in your statement, please, to page 6, where you talk about Lennox Castle Hospital.

At paragraph 22, you refer to having seen a brochure

for the opening day at Lennox Castle. And what did you see in that brochure?

A. Yeah, it always struck me -- I was shocked initially that it had only opened in 1936. So I'm born in '53, so when I'm born that's only 17 years. So the tendency to think of these places as Victorian and -- just not the case.

But there was this kind of glossy brochure, with adverts for -- the purveyors of baths and all sorts in it. But, at the core of it, there was a message from the guy who was going to be in overall charge, saying that -- how everyone does exceedingly well to be patient and put up with these difficult people.

It's a bit like the medical model again. It's like locating the problem within the people and saying -- it's a bit patronising as well, and paternalistic.

Q. And then you say that over time, your perception is that changed around the 1960s, because there was the growth of the civil rights and disability movement?

A. I think people with physical disabilities led the way. It was -- much more easy for them to voice their views and they began to say, internationally, and in a concerted campaigning sort of way, that: 'This way of behaving towards us is not acceptable. We should have the same kind of lives as everybody else'.

And so that kind of thinking from a civil rights perspective, the disability rights movement, starting in the sixties, it's a long process. It's not like things really began to change.

I don't think in Scotland things changed much before we got into the eighties, but that was the groundswell of it, I would say.

Q. Over the page, on page 7, it's continuing in paragraph 22, at the top of the page. It says, in your final sentence:

'As ever, with a change of culture in practice, those older ways of thinking take time to fade away and are stubbornly enduring.'

I suppose that would be within individuals. That then feeds into society's view as a whole; is that what you mean?

A. Well, there is something systemic about it. It's not just, you know, about individuals, it's -- the argument would be, I guess, that we end up with institutions because, in society, we have a poor, sort of, low value view of people with disabilities, and we're also a bit unsure about them. The sort of fear of the unknown. 'Who are these people? How do I relate to them? It's maybe better if we keep them separate or at some sort of distance from us. They might be a threat to us

physically', or ...

Yeah, so that kind of fear of the unknown, I would say, leads to institutions being -- you know, coming into play.

So if there is that -- you know, we have all been socialised in the same sort of way, so if there is that underlying fear of people who are different or other, then it does take time to -- for that to fade away.

I grew up -- I didn't meet a person with a disability until I started my social work training. So I had been -- there was no one in my family. There was no one at school. There was no one at university, and then I remember my first day as a trainee: 'We've organised for you to go to a day centre for the mentally handicapped'.

And I thought: oh, right, what's that?

So I remember that kind of jarring note and thinking: 'Oh, I don't know who these people are. Will it be safe?' And all of that.

And, you know, you come out at the end of the day having met some of the nicest people you'll ever meet. But I was 21/22 by that time. So if you generalise that to society as a whole, you know, that kind of lack of experience with people with disabilities -- hopefully, it's changed somewhat over the intervening years. But,

going back to fifties and sixties, that was -- you know, that sense of people being excluded or they go somewhere else, or we don't really see them. They're out of sight.

Q. You go on, at paragraph 23, to say that the cohort within Lennox Castle covered a wide spectrum of disability. Was that your experience of what you found when you went to work in Lennox Castle?

A. Oh, yeah, I mean, absolutely. You've got the whole spectrum. And there were people there who didn't have a learning disability at all, who had ended up there by circumstance. You had people who -- at the other end of the spectrum, who probably didn't have speech, were physically disabled also. And in between you had a whole range of people, some of whom were very challenging in their behaviour and some of whom were people with a mild learning disability. They were just putting in their days, not doing very much.

Q. When you say that some people had ended up there by circumstance; what sort of circumstances did you come across?

A. I think for women in particular, it was kind of dangerous to come across as a wee bit feckless, maybe, and particularly to have -- to become pregnant, have a child, maybe not have much family support. Probably

not people who are disabled at all. But it was a place that you could be taken to or advised to go to and then, you know, once you were there, very hard to move on or to get going again, to get your life started again.

Q. Now, under the heading 'First impressions', you say that you had been to Lennox Castle once before, before you actually went to work there?

A. Yeah.

Q. And at paragraph 25, you say:

'At the visit, I didn't really know what the hospital was for. It was outwith my experience at that stage. I didn't really understand it. It was like going to the poor house that my granny would have spoken about.'

A. Well, my granny would threaten me with the poor house, 'You'll go to the poor house.'

Yeah, it struck me as just -- this is -- it's almost kind of Dickensian. It's like, here's something that's completely separate from the mainstream of life that, you know, you don't encounter, you don't engage with, but there it is. It's not that -- it's 12 miles out of the centre of Glasgow, a wee drive in the car and you're there, and this kind of sprawling estate with strange buildings.

And I can't say I gave it a great deal of thought at

the time, because it was a one-off bit of work and it wasn't the focus of my work at that time. But, yeah, just odd, a kind of parallel universe, kind of thing.

Q. By the time you got there in the 1990s; did you have the impression that things had improved and changed from your first impressions?

A. The physical environment, the external -- things looked more coherent, you know in terms of a hospital, I guess, what a big hospital might look like. So there was none of the Nissen huts. They had gone. Some of the buildings had been knocked down or redesigned, or -- so, yeah, they looked better. There were still, internally, places where there was very little privacy. If you think of this being the place where you live year in year out for many, many years and you're just next door to somebody else, with not much space between you, not much space to secure your belongings, such as you may have.

So, to that extent, there was a bit of cosmetics, perhaps, associated with it, but there was still that kind of deprivation of dignity.

LADY SMITH: This was the 1990s?

A. Yeah.

LADY SMITH: Still looking behind the times in the 1990s?

A. Yeah.

MS INNES: You go on over the page, at page 8, paragraph 28, to talk about the way in which the wards had previously been split by gender. You say:

'By the time I was based there, they were still being kept apart, but not in the same rigid way in the sense that there would be a male ward next to a female ward, perhaps.'

You didn't think there were any mixed wards.

A. Yeah.

Q. Over the time that you were working there in the 1990s; do you know if there were any people under the age of 18 that were there for any length of time?

A. I think, given that you become an adult at 16, I think potentially there were some people relatively recently. They wouldn't have been -- during my time, they wouldn't have been admitted before they were 16. But they could have been admitted 16/17.

And, yeah, it was very much a kind of crisis move for someone, if, you know, things were not good at home and people were struggling, then Lennox Castle was still -- even though it might be on the verge of being closed, it was still a place you could find a space for someone to be accommodated.

Q. If we look down to the heading that you have there, 'Culture', paragraph 30. You say that your impression

of the culture was very traditional, authoritarian and quite macho in some ways. Can you explain that, please?

A. So there was an underlying kind of -- I don't know what the right word is.

There was an aggressive tone to a lot of what was said and done. There was -- you know, particularly coming from male managers that, 'We're in charge here. We direct things. We tell you what to do and we do it in that kind of fairly direct, West of Scotland manner', 'that's you telt' kind of thing.

So it wasn't, to me, a culture that encouraged open dialogue between equal adults, which I -- you know, you might have hoped would be what would be happening, even though, you know, there was that divide between staff and patients. We're talking about a group of adults trying to work together, you would hope, for the betterment of the folk who lived there.

Q. If we go on over the page, you talk a bit more about your role at Lennox Castle and, at paragraph 34, you say:

'Since about 1990, there had been social workers located there in an assessment role, with a view to maybe helping some people move out, people who were judged to be more able ...'

Then you say:

'However, we were of the view that nobody should have been there in the first place.'

So when you say 'we'; who is the 'we' that you are referring to there?

A. I suppose my peer group of colleagues. Yes, uh-huh.

Q. So there was an assessment team there?

A. Yeah.

Q. And there's the commissioning team?

A. It was being -- yeah, from '95 onwards -- it was constructed. It wasn't there previously.

Q. You say in this paragraph:

'The workers who were there were kind of in with the bricks.'

Are you referring to the social workers who had gone to make the assessments with a view to potentially having people move out?

A. Yeah, yeah.

Q. What do you mean; they'd become in with the bricks?

A. I think they bought into the general view, you know, that people wouldn't be moving out. There wasn't a lot of effort being put in to helping people move out. I think they had, you know, been persuaded somewhat that, you know, that people were better off just remaining where we were.

LADY SMITH: You say that it took a bit to turn them around.

Put shortly: what did you do to achieve that?
A. I think one of the things we did was expose them to colleagues coming in with a different perspective, and a manager coming in who expected different things of them.

We did do some training, some formal training as well, with the whole team, so the older workers and the newer workers come together with that manager. So, yeah, we tried to, kind of -- and we also introduced a new assessment approach. I think 'essential lifestyles plan' that I referred to somewhere. So it was a more person-centred, less, kind of, medical model format to the assessment, I would have said.

LADY SMITH: Thank you.

MS INNES: If we go on to page 11, and paragraph 42, you say that the commissioning team also had to go to other hospitals, such as the Royal Scottish National, at Larbert.

A. Mm-hmm.

Q. Because there were people funded by Greater Glasgow Health Board living in those places?

A. Yes.

Q. So was the view -- were you also looking to move people from RSNH into other settings?

A. Yes. So the name of our project was the Greater Glasgow

Learning Disability Project. It wasn't the Lennox Castle Project, and that was because, rightly or wrongly, people would be traced according to who had originally funded their placement in these places. So there was an enduring financial commitment from Glasgow, or Greater Glasgow Health Board, to people who were living in all sorts of places, up north, down south and in these -- Merchiston, RSNH, yeah.

There were equally -- well, not equally, but, to some extent, there were people in Lennox Castle funded by other health boards and there was that whole kind of disaggregation, very confused kind of picture because it had built up over so many years. And sometimes you were wanting the people's views themselves to determine what happened.

So, if you'd lived in Glasgow -- if you hadn't lived in Aberdeen for 40 years; what sense did it make going back there and vice versa? So some of that came into play, as well.

Q. I suppose all round about the same time, you've got disaggregation of local authorities?

A. Yeah.

Q. You had NHS trusts and they were going as well?

A. Yeah.

Q. So it sounds like it was a complicated --

A. Yeah, we had a graphic up on the wall one time and it looked like the London Underground map, so yeah.
Q. If we go on over the page, to page 12, and paragraph 44, you talk about the families' attitudes to the work that you were doing; what was their attitude?
A. 'Don't do it. This is cruel. People are perfectly happy here. There's lots of dangers out there in society that you will be exposing people to'.

Yeah, so 'we want the hospital to stay open', I guess would be their ultimate view, yeah.

Q. Then, at paragraph 45, you say that one of the things you had learned when you were up in Aberdeen was that if you were talking to a person or relative about moving a person to a house, you can't assume that they'll understand what a house is?
A. Yeah. So I was very naive and I would say: 'Oh, so, we're just thinking about moving [redacted] or [redacted] or [redacted], to a house' and -- thinking that we had a shared understanding of what that was and clearly we didn't.

Now, whether that was because, historically, places where people were accommodated didn't look like houses -- even if they weren't these big hospitals, they still didn't look like houses. They looked like hostels or ...

So it was a real learning point for me that if you

actually went with people to a house -- so we were buying some nice houses in Aberdeen at the time, expensive properties on the open market, and you would -- where some people had already moved in and: 'Oh, well, if that's what you mean'.

So there was that kind of conceptual barrier that ordinary housing was 'actually a possibility for my son or daughter'.

Q. That applied to relatives; would it also have applied if you were speaking to the residents of Lennox Castle, for example, or a long-stay hospital? How could they --

A. Yeah, even more so, even more so, yeah, yeah. And then you had some people had obviously been out of the mainstream of life for 40/50 years, you know, so, yeah.

Q. Then, at the end of this paragraph, you also mention that there was a lot of pressure from hospital staff, because their jobs and livelihood were at risk and you compare it to it being like the local factory shutting down, because of it being the main source of employment?

A. Yes, it was the main employer and it had been a big employer since the 1930s and most of the staff were recruited from within that. Not Lennoxtown exclusively, but that more, you know, general area, along the Campsies, yeah, so ...

Q. So over the page, at page 13, and paragraph 48, again

going back to the idea of an assessment, you say the information you were getting wasn't particularly reliable and you say it was precisely because you were assessing somebody in an institution --

A. Mm-hmm.

Q. -- that they perhaps weren't able to -- or, sorry, what impact did that have on the assessment?

A. I think the assessment was useful because you were spending time with an individual person and letting them understand that you were interested in hearing their story, and hearing what they might be -- might want the future to look like.

However, their experience of life very often was limited to that institutional environment, where, you know, if you had gone in as a child or as a young adult, you were operating within a very limited range of experiences and options. So assessing what someone might be capable of. You know, people blossomed in ways that you couldn't have imagined on meeting them for the first time.

Q. If we move on to page 15, please, and paragraph 54, you say that there was lots of space for residents who were quite autonomous, but then there were others who rarely stepped out of their own ward?

A. Mm-hmm, mm-hmm.

Q. And then you talk, at paragraph 55, of there being a number of locked wards, including more than one challenging behaviour ward. You say:

'There is no good practice rationale behind putting a number of people with challenging behaviour together. It's to do with labeling people.'

And then focusing on the work in the ward or the people that work in the ward; can you tell us a bit more about that, please?

A. Well, I mean, it's -- it kind of beggars belief in a way, but that's really -- and still persists to some extent today -- that the people whose behaviour is the most challenging will be grouped together. And not just in a small group here, but in a large group.

So people learn from each other. They watch each other's behaviour. People are fearful of each other's potential behaviour towards them. It makes the work of the people employed there ten times -- 100 times more difficult because, you know, you're bringing together a cluster of people who make the most significant demands upon staff.

So the ability to do anything therapeutic or developmental, you know, is constrained. So for all those sorts of reasons it's ... yeah, it's not a good idea. It doesn't work. It doesn't help people. And

I think, you know, if the research was read, if the evidence that had been collected around this was understood, people wouldn't do it, you would hope. But it's still a kind of default assumption sometimes that: 'Oh, yeah, we better create a unit for those challenging behaviour people, even if it's a small community unit'.

Q. If we move on, please, to page 16, at paragraph 58, you describe meetings with the health board and you describe them as quite often being conflictual, and you describe there being a tension between closure and trying to get people out as soon as possible. And I think you trying to make sure that the right support is in place. So that, on your view, I suppose, would take longer; that you couldn't do it straightaway?

A. Yes, there was a particular pressure to close an individual ward. So ideally for the folk that I'm in conflict with there, all of those 20 people, let's say, in that ward, if they could all move out at the same time, wherever they were going, then we could close that ward, we could cut off the electricity and other things, you know, we would make savings. So not a process that was centred on -- if you go along with that, it's just a kind of -- it's a facilities-led kind of thing.

But, within those 20 people, you maybe have people from Aberdeen, from different parts of the country,

people who wanted different things, people who couldn't move out together. And so we were certainly resisting the pressure to simply just work one ward at a time for that reason. We were trying to work across the whole population of the hospital and that led to some of these criticisms that, you know, it wasn't being done in that way and, therefore, not generating the savings. It wasn't being done quickly enough and certainly it wasn't being done cheaply enough.

Q. Then you go on in your statement to talk about some of what you learned from speaking to people who had lived at Lennox Castle about, for example, what the daily routine was like and suchlike.

If we go on to page 19 and paragraph 68, you say in that paragraph:

'For some people, this daily round of personal care or washing and dressing tasks constituted their lives. It's quite shocking when you see it and feel it.'

Can you explain a little bit more about that, please?

A. Well, I didn't see it and feel it until I was -- I spent some time at Kirklands Hospital, later on.

But, yeah, that's ... and probably -- it's hard to know how you, you know, fill in the gaps in your knowledge and understanding over time. But, from what

I heard from other people as well, there was a lot of life that consisted of the next meal, preparing for the next meal, waiting for the next meal, watching the telly, falling asleep watching the telly, listening to endless rounds of Jimmy Shand playing over the radio or whatever the device would be.

So once the personal care tasks were dealt with, once the feeding tasks were -- you know, people getting up and dressed and ready for the day, the day consisted of nothing, really, other than the next meal. And so ...

Q. And you say at the end of that sentence:

'The underlying assumption is it's almost like they are not experiencing anything, not fully human or something. There's nothing much going on in the head or heart.'

Can you explain that, please?

A. The best explanation I can give you of that is -- and it's not from Lennox Castle -- but I was once working with a man up in the north-east, a man who had no speech and a physical disability, and I was having a meeting one day with a social worker about him and the social worker was based in Stonehaven and he said, 'See, it wouldnae really matter to this chap whether he was in Stonehaven or San Francisco'.

That's what he said to me. So it's that kind of devaluing set of assumptions about someone that doesn't speak, has a physical disability, that they're not -- they're not like you or I. These things -- things that might matter to you or I don't really matter to them and, 'Who knows what's going on in his head'.

Q. Then, at paragraph 70, on the same page, you talk about washing and bathing. You say that things had improved in the 1990s by the time you were there in terms of privacy. You say:

'There had been enough instances in the past of staff being disciplined for grossly invasive treatment, leaving toilet doors open and not caring about privacy or dignity.'

A. Mm-hmm.

Q. How did you know that that sort of thing had happened?

A. That would be based on reports I would get from colleagues, either in the assessment team or the commissioning team.

Q. Okay.

LADY SMITH: And you were a commissioner, John, were you?

A. Well, I personally wasn't because I was leading -- I was kind of above the assessment and commissioning team in the structure. So the ultimate activity was commissioning social care, so in that sense I was, yeah,

yeah. But it wasn't my day-to-day job in the way it was for some of my colleagues.

LADY SMITH: And if somebody did have being a commissioner as part of their day-to-day job; what did that involve?

A. That involved meetings with organisations which might potentially provide support to people.

So, by and large, the people who were providing the support in the hospital weren't moving out with the people. There needed to be new -- and also there was a move, really, from NHS support to third-sector social care support. So there was a whole kind of infrastructure having to be created there.

So they were having those meetings with potential organisations and then they were commissioning them to take on the work with individual people or groups of people.

LADY SMITH: That makes sense. Thank you.

MS INNES: And then you go on in your statement, John, to talk about other aspects that you were told about, either through colleagues or by people who were residents.

If we go on to page 22, at paragraph 86, you say that you were aware as a practice of privileges being withdrawn as a form of punishment. Was that going on in the 1990s when you were there?

A. Yeah, yeah.
Q. You say you wouldn't be able to give specific examples of that, but you understood that it seemed to be part of the culture?
A. Yeah, yeah. Again, I'm relying on reports from others about that.
Q. Now, if we can move on, please, to page 24 and paragraph 93, you talk there about something that you were told by your father-in-law, who was a plumber and had to do a job at Lennox Castle in the 1970s?
A. Yeah.
Q. What did he tell you?
A. Well, as it says there, he had a colourful way of expressing things, I would say. But he talked about people being hosed down rather than bathed, in front of each other. People going to the toilet, but the doors being kept open. Just that kind of -- it's almost, you know, concentration camp kind of image of complete loss of dignity.

I certainly never saw anything like that. And certainly by the nineties, I doubt that that would have been tolerated. But he was reluctant to do anything about it. It was a long time ago as well, by then, you know. But it was when he knew I was working there and he said, 'Oh, aye, I went to work there', and out came

this story. I mean, absolutely horrific.

Q. If we move on, please, to page 25 and paragraph 95, you say that your overwhelming sense of places like Lennox Castle was neglect:

> 'It wasn't so much high-profile incidents, but a general culture of neglect.'

A. Mm-hmm.

Q. And then you go on to refer to issues that you have already mentioned: the routine; the lack of stimulation; low expectations; environment in which your humanity is in question.

And then you go on to say that you had read something where the United Nations said that institutionalisation is an assault?

A. Yeah.

Q. Was that in the context of the UNCRPD that you refer to there?

A. Yeah. It was UNCRPD being quoted in the context of the Tick Tock Report. That's where I, sort of, read it afresh. For me to see, it's quite a dramatic way of thinking about it. It's an assault upon the person to be institutionalised in that way.

Q. We'll come back to that report which was published by the Scottish Human Rights Commission in January 2025. We'll come back to that in your evidence in due course.

If we can move on, please, to page 26 and paragraph 100, I think you are being asked there about, you know, complaints or whether people would feel the ability to raise issues. You say that you don't think that there was a channel for individuals to complain because of subordination and dehumanisation. How does that impact on someone's ability to complain or challenge?

A. I'm not sure if there was a channel of complaint for residents. There may have been formally, officially. It certainly wasn't publicised or up in big letters on the wall, saying: 'If you have a problem, go to so and so'.

Q. And then at paragraph 102, you say that there was also a concern that people didn't acknowledge or understand what was happening to them was abuse?

A. Mm-hmm.

Q. Why do you say that?

A. I think if that's what you've known from your earliest days, then -- and I'm speculating here, because it's not my experience, but how do you know what's right or wrong? Or, you know, you can experience misery and sadness, pain, hurt, et cetera, and some people you would know were feeling that way because of the way they behaved. They would say -- you know, they would tell

you through your behaviour: this is not okay.

But there would be other people there, I think, who maybe just thought, 'Oh, this is what life is like' or 'This is the way life has worked out for me', so I don't know that they would necessarily always conceptualise it as abuse in the way that we would.

I don't imagine anyone thought, 'Oh, this is great' or 'I'm having a great life', but knowing it was abuse and knowing it was something you could complain about or that there were structures, because you were in a very low, almost powerless position with people who would say that you lacked capacity. That would be frequently said, as a generalisation, when what they're talking about is reduced decision-making capacity. But it would be used as a kind of catchall for that kind of subordination.

Q. Now, you go on, on that page, to refer to a chief executive called Tim Davidson, and you say that there was an inspection report around that time.

You say you can't remember the name of the body that went around the hospital doing the inspections, but the body carried out an inspection which was damning of what it found. It was an independent team.

Then, at paragraph 104, you say:

'Tim Davidson spent weeks and weeks and did

eventually succeed in getting that report modified and toned down in its criticism.'

Can I ask you, please, to look at INQ-0000000832, which -- the first bit is extremely small, but it's pictures of a news report, which if we scroll down the page, we'll see it was in Scotland on Sunday, September 21, 1997, and the headline is:

'Row as doctored report spares trust's blushes.'

LADY SMITH: Can we try enlarging that to see if it gets any better? Oh, it disappears off the side of the screen, does it?

MS INNES: It becomes pixelated. At the very bottom of the page, there is a transcript, essentially, of the report.

LADY SMITH: Thank you.

MS INNES: It goes on to the next -- so if we look down to the bottom, it says:

'Row as doctored report spares trust's blushes.

'Experts claim edited highlights of official report into Lennox Castle ignore condemnation of unacceptable conditions.'

If we go on to the next page, we see that it says:

'An official report on conditions inside a Scottish psychiatric hospital was doctored to save a health trust's embarrassment. The final report on

Lennox Castle Hospital outside Glasgow was only mildly critical when it was published last month, but the original draft was infinitely more scathing. It condemned management, basic standards of care and reported patients' complaints of physical and mental abuse.

'The changes to the original draft by the government agency, the Scottish Health Advisory Service meant whole passages were changed or omitted, watering down a highly prejudicial tone and resulting in a much milder compromised document which has proved less embarrassing to Greater Glasgow Community and Mental Health Services NHS Trust and attracted only minimal adverse publicity.'

First of all, pausing there, that sounds like the report that you are referring to?

A. It does, yeah, yeah.

Q. And are you familiar with the agency, the Scottish Health Advisory Service?

A. Yeah, it comes back to memory now, the name of it. In fact, I did serve on some of the teams that the Advisory Service would construct to go and visit other facilities and hospitals, so, yeah.

Q. And that would have been in your role as a social worker?

A. Yeah.
Q. You would form part of a sort of ad hoc team?
A. Ad hoc multi-disciplinary kind of team, yes.
Q. This goes on to say:

'The seven authors, all experts in care provision, are divided over the legitimacy of what happened to the their assessment, some accepting the changes as normal editing, others contemplating resignation before reluctantly agreeing to put their names to it. None would comment openly ...

'The SHAS report revealed unacceptable conditions, including the smell of urine, dirty kitchens, insufficient staff and poor services for patients. It referred to residents' unhappiness at being restrained by sedation or confinement to bed, regarding the practices as punishment rather than treatment.

'But draft report was couched in more graphic language, unacceptable methods of control. These include their arms twisted behind their backs, the use of cold showers, the removal of shoes and money as punishment.

'It also mentioned several reports from residents and others of staff swearing at and insulting residents.

'The published report referred to residents sometimes biting, scratching or hitting each other. The

authors originally wrote: "We are not convinced that such serious incidents are always accorded the attention they deserve to protect the rights of all concerned".'

And then it goes, again, back to the original report. It says:

'Authors originally said that staff had no commitment to improving quality care with ward service ticking over and few signs of energy, enthusiasm and drive and everybody working with no clear vision of the future and confused priorities. Communication was said to be rarely personal and mainly written. The original appealed for a different approach to leadership. None of these criticisms appeared in the final version.'

And then the next page goes on to give a couple of comments from people, and there's a comment from the director of ENABLE.

The next paragraph says:

'But Dave Watson of Unison which represents nurses at the hospital claimed most of these outrageous allegations the authors cannot substantiate.'

And it was admitted that the report was toned down because information couldn't be nailed down. Then there is reference to Tim Davidson describing the admitted comments and abuse as 'potentially criminal behaviour', claiming they were left out because SHAS 'couldn't

substantiate them'.

Is that consistent with what you -- I think you said in your statement that you could remember there were political issues around the report?

A. Yeah. Yeah, so I obviously knew the visit had taken place. I knew that a report was being compiled. I had heard on the, kind of, grapevine that it was a very negative report, and then it was never -- it was never coming out. You know, weeks and weeks were passing and I was aware that there was lots of meetings taking place above me in the structure, about how it might be altered or changed, or, you know -- so, yeah, it was very -- very -- but there's more detail there than I would remember or maybe even know about at the time, because, you know, it was other colleagues of mine who were perhaps involved as well as -- I guess mostly the health board and the trust having those discussions with SHAS.

Q. Just finally on this article, it also mentions the then Scottish Health Minister, Sam Galbraith, who was both the local MP and now Health Minister; did you meet Mr Galbraith in the context of your work?

A. I did, on one occasion, at least, yeah, yeah.

Q. What was his attitude to the closure of the hospital?

A. He was the local MP. I mean, he was Health Minister,

but he was the local MP, so there were votes in it for him to keep the place open. And he had a meeting with us that particular day that I remember him. But he was quite supportive, asked some interesting questions. He later wrote an article in the newspaper, which -- about that meeting with us, where, you know, it was quite critical and, I mean, you know, there was a lot of shuffling of feet, I remember him saying.

But he went directly from that meeting down the hill to the bottom of the site, had a meeting with staff and told them that, 'This hospital will never close'.

So there was a two-faced aspect of it with him and, you know, he was -- he was party to the Daily Record story as well, which I referred to in my evidence.

MS INNES: We'll come back to that later on. My Lady, I'm conscious of the time.

LADY SMITH: John, I usually break at about this time in the afternoon; would that be all right for you?

A. Yes, thank you.

LADY SMITH: We'll have a short break.

(3.02 pm)

(A short break)

(3.13 pm)

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

A. Yes, that's fine.

LADY SMITH: Thank you.

Ms Innes.

MS INNES: Thank you, my Lady.

If I can take you back to your statement, John, and to page 28, at paragraph 111, you are talking there about one of the former residents of Lennox Castle and you say that he had been quite young at the time that he was admitted. Then you talk about him having had a supportive family, but things had got out of hand and he'd been admitted.

You say that he was blind and was in a challenging behaviour ward:

'He had a reputation for biting people. He would be placed in the corner with his back to everyone else [as we go on over the page] he had no idea what was happening.'

And then you say other patients would come up from behind and antagonise him. You go on to say that there was a spiral here and you give this as an example of there being no rationale for what was going on.

A. Yeah.

Q. And, in particular, he was in what was called this challenging behaviour ward, with no expectation he would ever get out; is that right?

A. I think he had such a reputation as an individual that it was assumed, probably, that if and when hospital closed, he would move to some other institutional kind of setting. That, you know, he could never live in the community.

Q. Then you go on to say that, in fact, he did move out and move into the community. You say that in the early days somebody did get bitten, but it was a behaviour that faded away?

A. Yeah.

Q. And he's been living in his own house for many years now?

A. And still does, yeah, yeah, yeah. Happily.

Q. If we move on, please, to page 34 and paragraph 130, this is where you give us some reflections, or broader reflections. You refer to a study that was carried out by the Scottish Office in 1987 called:

'The study of the balance of care.'

And you say that in that study it said for every person living in a learning disability institution, there was a similar person living in the community.

A. Yeah.

Q. Are you saying that in 1987, it ought to have been realised that people with learning disabilities could live in the community or was this a report that then

moved that forward?

A. I think it helped move things forward. I think the researchers were called Baker and Urquhart, and they went round all the -- I remember meeting them at the time at Dingleton Hospital and, as I say there, I think it gave the lie to the -- there would be a school of thought that said: 'Yeah, okay, most of these people can live in the community, but there are some people who will always need an institution'. And it gave the lie to that. That, you know, that institutional living is necessary or beneficial for anyone became harder to hold on to as an argument.

Q. In the next paragraph, you talk about transition points being key and you talk about the transition from childhood to adolescence?

A. Mm-hmm.

Q. And I think we have heard evidence that, for example, that at Lennox Castle, a pinch point would be when a child moved to adolescence and then they moved into institutional care?

A. Yeah.

Q. What are your reflections on that, and what can be done to address these particular points of time?

A. I think in our experience, particularly for young men -- and it's not exclusively for young men, but young men

with autism and learning disability coming into puberty. Adolescence can be a really, really difficult time and it's a time when often behaviour changes and families struggle, don't always get the support they need to assist them with their son. And they will quite often turn to the authorities, to social work, to health, you know, for help and, sadly, what often happens is that that will lead to the person leaving the family home and going into a kind of holding -- no, that's not correct, a treatment facility, let's say. NHS treatment facility, it would be called. And then find themselves still there years later. So that bit of the system that tries to help at that crucial transition point in life often leads to damaging consequences for the person.

There's all sorts of medication comes into play through that kind of NHS treatment and there is that kind of negative spiral. So the longer you're in the institution, perhaps the more difficult your behaviour becomes. The more medication's used, the more your reputation's damaged, and people will then -- in that bit of the system, will say: 'It's going to be very difficult for this man to go back into the community'.

So there's the preventative issue here. It's getting support to the person and the family in the community in way that doesn't bring all these unintended

consequences with it.

Q. Now, if we move on to paragraph 135, on page 36, I think you're referring to that concept that you just spoke about. It being an -- institutionalisation being a vicious circle. You get a reputation. You're segregated. You lose some skills. You're viewed in a further negative light.

A. Mm-hmm, yeah.

Q. And then you talk about there's potential life-long consequences in terms of its impact on society and offending behaviour, perhaps?

A. Yeah, yeah.

So, yeah, it's -- I think the bit about, you know, you go in there for treatment, but you get worse and you may be -- there will be -- elements of the Mental Health Act then used to detain you. All sorts of hoops you then have to jump through to be able to get out again. And it's not the sort of process that's effective or efficient in helping people manage their behaviour, to develop through adolescence and into young adulthood. It's a sort of intervention that means you may, as a teenager, find yourself there. You may be struggling to find your way out by the time you're 30 or 40.

And it would be nice to think that didn't happen anymore and that we understood, from the work that was

done in places like Lennox Castle, that anyone with any type of disability can be supported properly in the community. But it's as though that -- it's as though our collective memory's been lost to some extent. You know, that while those people were coming out -- and that's why that broad spectrum issue was really important. There was no one in there who -- or there were people living in there who would -- it's a bit like the Baker and Urquhart thing, they would have their equivalence with the people who are now detained in these places.

So it's as though we don't join up the dots and, as people move out, we forget what it took to help them come out and support them successfully. And then, as a consequence, other people go into institutional settings because, you know, it's as though we don't really know how to work with them or to help them properly, you know. So it was very frustrating in that sense.

Q. If we go down to page 36 and down to paragraph 137, you talk there about a person Jim Mansell, who had written a publication for the Home Office in relation to the best policy for those with autism, learning disabilities and/or challenging behaviour.

A. Yeah.

Q. You say that he said that people just needed a home to live in and proper support. And I think he then reiterated that, you tell us?

A. Yeah. He was asked to write the report again, and I think -- when would that have been? Just shy of 20 years later. It was as though 'maybe you would have a different view now' kind of thing, and he didn't. You know, he -- and I think it points to an underlying issue about the ability for the organisations involved to act on the basis of evidence and information and knowledge. For whatever reason, that seems to be really difficult.

So the public policy around people with challenging behaviour, autism and learning disabilities for a long, long time has said: 'This doesn't work. Keeping people in institutions like this doesn't work. What you need to do is to work with individual people in a home environment, with the proper support. That's what brings results and it's no more expensive', if that's a concern that people have.

But people keep on doing the institutional thing and there's a whole discussion to be had there, I think, about why that's the case.

Q. If we go on over the page to page 37, paragraph 139, you refer there to the Scottish Human Rights Commission's Tick Tock report; can you tell us a little bit about

that report and its impact?

A. Yeah, so the context for this report was a Scottish Government report -- I'm trying to remember what it's called. It's the 'Coming Home' report. I can't quite remember the year it was published. But it is said there were around 700 people -- which was probably an underestimate -- 700 people living in institutional settings or out-of-area placements, some in Scotland, some elsewhere. And the report expressed a commitment to doing something about that, to helping people move away from those situations over time.

Nothing much really happened as a result of that report. There was very little progress made across the board. And so the Scottish Human Rights Commission's report was specifically looking at the human rights issues involved in the lives of those people and the commitments that had been made and not fulfilled and, yeah, so that's the broad context.

It's related to the 'Coming Home' report, but I guess the principles that it espouses are relevant to the whole population that we're speaking about here.

Q. Then you go on in the 'Lessons learned' section, at page 38, at paragraph 145, to talk about self-directed support. Does this, in your experience, apply to children as well as adults?

A. Yeah. It's the law governing all social care of children and adults.

Q. You essentially say, I think in your comments, that this is a good idea, but it's not being used to its potential; is that right?

A. Yeah. So -- yeah. I mean, it's about people themselves having the power over their own -- power and control over their own lives, with the necessary levels. It's not just about people with learning disabilities. It's social care across the board.

I would think it's a good idea, because of my, kind of, perspective on things. But, even if somebody else didn't think it was a good idea, it's still the law of Scotland, as I understand it, that this is how social care should be governed and administered and implemented. And it's very, very frequently the case that it's ignored, I would say.

Q. If we go on to page 40, you refer there to some of the issues that you find with the implementation of self-directed support. You say that if the National Care Service had been implemented, that might have made a difference, but you don't know.

Then you go on, at paragraph 151, to say what Mansell's response to the Winterbourne View scandal was?

A. Yes.

Q. And his response was:

'It's just the wrong model of care.'

A. Yeah.

Q. That takes you back to your views, I think, in relation to institutionalisation. Even if you improve it, you say it's still going to fail?

A. Yeah. It's superficial, trying to make the institution better. It's rearranging the deck chairs on the Titanic to some extent. You know, you're not really tackling the issue and, ultimately, the issue is for the individual man or woman or child. It's about their life. You're either respectful of their humanity or you're not. You can't have it both ways.

And there's such a gap between what we know, both in terms of what the human rights legislation says and what good practice imperatives say. If you put those two together, such a gap between that and what we actually do. And with self-directed support somewhere in the middle there. You know, that we're supposed to comply with this way of working, which is grounded in human rights and a broad view of what a good life looks like for someone.

And for all sorts of reasons, some of which are economic, we're constrained to work in a way that still limits people and still assumes, ultimately: 'Well, you

might just have to go into an institution because that's all we can afford or think of'.

Q. Thank you very much, John. I don't have any more questions for you.

A. Thank you.

LADY SMITH: John, nor do I. But I do want to thank you for the time and trouble you've put into engaging with us to help us with your evidence in both written form and coming here this afternoon. Thank you for being so frank. That also is a great assistance to me.

A. Thank you.

LADY SMITH: I am now able to let you go back out into the lovely spring weather.

A. Okay.

(The witness withdrew)

LADY SMITH: Ms Innes.

MS INNES: My Lady, there is time for a read-in and Ms McMillan will deal with that.

LADY SMITH: Thank you.

MS MCMILLAN: Thank you, my Lady.

This is the statement of an applicant who wishes to remain anonymous. He will be known as 'Duncan'.

The reference for 'Duncan's' statement is WIT.001.001.0336.

'Duncan' (read)

MS MCMILLAN: In his statement, he says he was admitted to the Royal Scottish National Hospital at four-and-a-half years old and he remained there until he was 16. Records, however, show that he was admitted in [redacted] 1966, aged 12, and discharged in [redacted] 1972, aged 15.

'Duncan' was born in 1957. He tells us at paragraph 2 about life before he went into care. He lived in Falkirk with his parents and sister. His father was an alcoholic and used to physically abuse him. He would often run away as a result.

At paragraph 4 to 44, he talks about his time in the Royal Scottish National Hospital at Larbert. He says:

'I still don't know why I was subsequently put into care at age four-and-a-half. I was to remain in care at the Royal Scottish National Hospital, Larbert, for the next 11 years of my life. I did suffer from pneumonia as a child, but I'm not sure if that's the reason they put me into the hospital.'

LADY SMITH: Did I pick you up correctly: the records we have been able to recover show him being admitted much later, not at four-and-a-half, but 12 years old?

MS MCMILLAN: Yes, my Lady.

LADY SMITH: Thank you.

MS MCMILLAN: 'I also ran away from home when my father beat me. I never appeared at a children's court or anything like that. Some of the patients had been at Carstairs Hospital and were much older than me.

'I remember being taken to the RSNH in a car. I don't know who was driving. I was with my mother and a social worker. We were met at the hospital by a Dr Primrose. I think he was the head man at the time. I remember that the hospital was huge with four large blocks in the institution part. There was an area called The Colony which had chalet-style dormitories. The whole hospital was contained inside a large fence. If you wanted to go into the huge grounds, you had to be accompanied by a member of staff.

'There were four blocks at the male part of the hospital. There were three floors in each block. Each floor had about eight dormitories with between 25 and 40 beds in each dormitory. I think there were two chalets also containing about 25 to 40 patients or inmates. There was also a female only part of the hospital, which I never visited. I think that it was similar in size to the male wing. The occupants in each dormitory were of all ages and included adults and children alike. This changed after I had been there for a while. I must have been about 11 when they built more villas.

'I was taken by a nurse and put into block three. I remember being taken away from my mother and walking down a staircase to a veranda or covered hall. I was then admitted into block three. The grounds and surrounding area were all fenced in and you were not allowed to go for a walk without a nurse present.

'I think that the whole hospital was run by the National Health Service, but I never asked and was never told.

'There were two parts to the hospital. The institution part, which housed the blocks and the colonies part which housed the villas. The institution part is now demolished. A railway ran through the middle of the grounds. This area was called Bellsdyke. Bellsdyke was where the grounds were.

'The residents of the hospital varied in age from about 3 or 4 years of age to much older men. We were all put in the dormitories and you could be in a dormitory with all different aged people. There were adults and children together. After I had been there for a few years, they built additional villas for the older men. You would be rewarded for your good behaviour and moved into the villas or when you were older and needing less supervision.

'There was a system where, if you behaved, you would

be rewarded by being moved to the colonies where you had extra privileges, like being able to stroll in the grounds on your own or being allowed to go into Larbert unaccompanied. You had to earn these privileges.

'You would be wakened every morning at 8.30 hours and the day would begin with getting washed and then breakfast at 9.00 am. You would get a bath once a week. When you got up in the morning, the dormitory would be locked behind you. You would get dressed in the corridor outside the dormitory, where your clothes were kept. I never went to school and there were no classrooms that I was aware of where I could do normal schoolwork. After breakfast, we started doing all the cleaning of the hospital. I was left alone until I was about 6 or 7 and that is when I had to start work. We would be on our hands and knees cleaning the long corridors or making beds. We did not attend school.

'When I became a bit older, I started being put into therapy sessions where we would weave baskets and that sort of thing. When I was older, I was put into the cement sheds, where I worked most of the time. I hardly had any schooling as I was working all the time. All the work was done at workshops in the hospital grounds.

'I had to wear a uniform which consisted of khaki shorts and other normal clothes. The RSNH was sewn into

the material. You also had a suit for Sundays. The underclothes were changed every day as there was a big laundry on site. The staff also used to wear a uniform which told you what rank they held. The male staff wore a white coat or a brown coat, depending on what they were doing at the time. The brown coat was worn when they were in the workshops.

'You were not allowed to wear your own clothes and you were not allowed to have your own possessions.

'Work started at 9.00 am every day and finished at 4.00 pm. Bedtime was at 8.00 pm. Before going to bed, you were able to play snooker or watch television. You got your supper and then you were put to bed. The dormitories were kept locked during the day. At nighttime, the staff would come in and waken up the bed wetters.

'Block 5 was where you were sent if you got into trouble or if you were caught running away. There was also a place called the box room, where you were imprisoned in solitary confinement and usually in a straitjacket.

'We did get some pocket money, which you could spend at a small cafe and shop which were in the grounds of the hospital. That was a place where you could take visitors to have a tea or coffee.

'The food at the hospital was adequate, but tasteless as it was all steamed. There were no choices, but there were no penalties for failing to eat what was served to you.

'I received no schooling to speak of. I suppose that my behaviour, running away, meant I spent most of the time in the workshops. I have since been able to teach myself basic reading and writing, but I still struggle badly as a result of a missed education. I worked in the cement making workshop and also on the farm, which was within the hospital grounds. I liked the farm because it made it easier to run away.

'There were no holidays at the hospital as the routine just carried on. I do remember going on two day trips. One to Aberdour and the other to a children's home somewhere.

'Some of the older patients could work outside locally and earn money. Some of them would save up to go to football matches. You could go to the pictures on a Tuesday. On a Sunday you could go for a supervised walk. It was embarrassing as all the local people knew who you were and where you came from. They thought that the RSNH was a mental hospital and looked at us very suspiciously.

'There were no birthday celebrations at the hospital

... You did get a present at Christmas time and there was a celebration of sorts.

'I was not aware of any officials visiting the hospital. I can't recall any visits from social workers.

'I did receive one visit from my mother during my whole stay at the hospital. She called to visit with her new boyfriend. I thought I saw my father one day outside the grounds of the hospital. I thought he was coming to visit me, but he never came in.

'The whole time I was at the hospital, I was put on medication. I was permanently on two drugs, Agapato and Oxport 100. These were the names that I remember. I received those twice daily in tablet form. I would get the first dose in the morning and the second dose at night. The staff always checked that you took the medication. They would hold your nose and hit you on the throat to make sure I swallowed it. I think this medication was given to me to keep me calm and controlled.

'There was a medical wing at the hospital, which housed the treatment unit. The hospital had its own doctors, so there was no need for doctors from outside the hospital. You would go there if you had physical injuries that required treatment. I recall being

battered by one of the members of staff on my legs, which drew blood. I was taken to the hospital wing and was bandaged up. I don't think that the staff even asked how I came about my injuries. I was never taken to hospital outside the grounds.

'On the many occasions I ran away from the hospital, I would be brought back by the police. The staff would give me an injection of paraldehyde. I would also be put into a cold bath. If I resisted in any way, I would be put into the straitjacket and put into the box room.

'Basically from day one in the hospital, the staff would hit you for no apparent reason and some of these batterings were very painful. The physical abuse was relentless and you didn't know when it was going to happen. There was no instruction from the staff as to how to behave. A lot of the fellow patients in the hospital were very violent and were constantly fighting the staff and each other. I still have scars on my legs where I had been hit by members of staff and blood was drawn.

'Things started to go badly for me the day I retaliated to being hit. I was cleaning one of the corridors when I accidently splashed some water on one of the female nurses. The nurse hit me with a brush and I immediately retaliated by striking her with the brush.

This was start of all my problems. I was taken to villa 5 and given an injection which knocked me out for several days.

'On one occasion, a ... nurse asked me if I would go to his room and help him move something. The staff quarters were out of bounds to the residents of the hospital. While I was in the room he tried to sexually abuse me, but I managed to get away. I had never been in this area before, so in my attempt to escape I was seen by other staff members. The nurse then accused me of stealing something from his room. I tried to tell the other staff what had happened, but they would not believe me. That was the hardest part, when no one would believe you and no one would listen to what you had to say.

'I ran away a lot trying to get to my grandmother's house in Bonnybridge. The police would pick me up there and bring me back to the hospital. I would then be put into a cold bath and given an injection which would knock me out for a few days. I would be locked up in block 5 and would have my privileges withdrawn. I was running away to get away from my abusers.

'The staff had a large leather belt which they would use for discipline. It was a tawse, like a school belt. They would hit you with this when they felt that you had

done something wrong.

'I was put into a straitjacket once and given an injection after I ran away. The staff held me down and injected me in the bottom. I was then put into the box room, where I was kept for about a week. The box room was padded. The problem was that your arms were restrained and you just had to go to the toilet in your clothes. At nighttime they would let you clean up. I think that I was aged about 9 when this happened.

'There were patients in the hospital that had both physical and mental problems. There were some kids I would call mongols at the time. All the while there was abuse going on with these people. The abuse was physical and sexual, but you just thought that it was normal behaviour.'

LADY SMITH: That expression, we know, was at that time used to refer to people who had Down's Syndrome.

MS MCMILLAN: Yes, my Lady:

'The sexual abuse didn't really start until I was about 12 years old. The first incident was the ... nurse. He tried to get my trousers off and tried to touch my privates. He was wrestling me. I managed to get away from him. Because I was in the nurse's quarters and I wasn't allowed there I was seen by other staff. He accused me of trying to steal. They all

believed him and I was not believed. I was given an injection and put into the straitjacket.

'The sexual abuse occurred on a regular basis when patients and members of staff would get into your bed and start touching you. They would then force you to masturbate them and perform oral sex on them. There was further penetrative sex which continued to the end of my time at the hospital.

'I thought that this was not right, but the behaviour was all I knew. I thought that it wasn't right, but I couldn't understand it.

'The staff would threaten you so that you didn't report it. You used to get called an "arse bandit" by the other residents. We never really discussed what went amongst the other patients as it just wasn't done.

'I found that I was running away more and more to avoid the sexual abuse.

'Every time I ran away I tried to tell the police, who took me back, what was happening to me and how I was being abused at the hospital. All they ever said to me was that I had to go back. They never conducted any enquiries to my knowledge. I was never interviewed about what I told them.

'I did try to tell members of staff about what was happening and I remember telling ... nurses at the

hospital about what happened to me, but they didn't do anything. Not all the staff were bad and quite a few looked out for me, including Mary Easton who used to give me cigarettes, despite the fact I was too young to smoke.

'When we were physically abused and had to go to the treatment area, no one there ever asked how I came about my injuries. I have never made a formal complaint to the police or social work department. I did not have a visit from a social worker the whole time I was in the hospital.

'With the help of a member of staff at the hospital, I wrote a letter to the Scottish Home Secretary questioning as to why I was being held at the hospital. A short while later I got a reply from the Home Secretary, I think it was Colin Campbell. The letter said that I was no longer required to remain in the hospital as I was an informal patient. The letter also suggested that if I was going to leave I should discuss the matter with the doctor in charge. I was free to leave hospital after 12 long years. I would be about 16 years old. I had been there for nearly 12 years and still have no idea why I ended up there in the first place.'

'Duncan' then tells us about what happened when he

left the RSNH, at paragraphs 43 to 45 of his statement.

He went initially to his mother's house and then his aunt's house. He was then sent to a children's home, where he says:

'Life was quite good there, but I had become institutionalised. I didn't trust anyone. I didn't know that these staff at this place were trying to help me. I was very suspicious. It was the old problem of trying to survive the best way you could, as I felt these people were against me.'

'Duncan' then had further periods in and out of care.

Beginning at paragraph 54, he talks about the impact of his time in care. He says:

'I have found it very hard to socialise with people and I don't like being in crowds. I hate being in any hospital and get very agitated, as I feel like I am back in the institution. I do not like anything to do with medical things. I feel that I constantly let people down.

'Because of the sexual abuse I am unable to let anyone touch my mouth or examine the inside of it. I have a great difficulty swallowing and often start to feel sick when I try to swallow food.

'I never got an education. I am not good with my

hands and could never hold down a proper job. I did try to train on a government scheme as a bus driver, but I was unable to cope with the money side.

'I have always been very soft with my children, so that they wouldn't have to experience what I did. My wife did not understand what had happened to me and it did cause problems between us. When we had our children we were better able to cope as we had responsibilities which took up our time.

'I have never been able to have a complete night's sleep. I have a lot of flashbacks in my time in the RSNH. They were always very unpleasant and cause me to get further agitated.'

'Duncan' then discusses the difficulties he has in trying to obtain his records. At paragraph 67, he tells us about the lessons that can be learned from his time in care.

He says:

'You have asked me about the lessons to be learned and I would say that children should not be put into care. If they are there, there should be checks done as to the reasons and the institution that they are going to. There should be close monitoring of children when they are there. You do not want what happened to me to be repeated. I was very much "out of the frying pan and

into the fire".'

'Duncan' says:

'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.'

'Duncan' signed his statement and it was dated 13 September 2016.

LADY SMITH: Thank you very much.

And the plan for tomorrow morning, 10 o'clock start with oral evidence as usual. There will be other oral evidence in the day as is set out on the website.

MS MCMILLAN: Yes, my Lady.

LADY SMITH: Thank you very much. I'll rise now until 10 o'clock tomorrow morning.

(3.54 pm)

(The Inquiry adjourned until 10.00 am on Wednesday, 7 May 2025)

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