Wednesday, 7 May 2025

(10.00 am)

LADY SMITH: Good morning, and welcome back to our hearings in this phase of our case studies.

As we said last night, we move on to further oral evidence today and I'm advised that we're ready to go; yes?

MS INNES: Yes, my Lady.

The first witness is anonymous and has the pseudonym 'Katniss'. 'Katniss' was admitted to Ladyfield on [redacted] 1981 and discharged on [redacted] 1983.

As she says in her statement, she stayed at Ladyfield during the week and spent the weekends in Carsewood Children's Home in Howwood.

LADY SMITH: Thank you very much.

'Katniss' (affirmed)

LADY SMITH: 'Katniss', thank you for coming along this morning to help us by giving oral evidence in addition to the written evidence that I already have from you. Of course, the written evidence covers more than we're going to particularly focus on today, because we'll particularly focus on Ladyfield. But I've seen it all and it's been really good for me to be able to get a full understanding of what you wanted to tell us in total about your life when you were a child.

The statement -- I see you have found already -- it's in the red folder there on the desk in front of you. We'll put parts of the statement up that we're referring to, like that, as we go through your evidence, if you're happy with that. If you want the screen off --

A. Can I just say one thing before we start?

LADY SMITH: Go on.

A. I don't mind, on the legal records -- of my dead name, but I don't want that made public.

LADY SMITH: That's fine. I think I had already been advised of that. We can see to that 'Katniss'; that's not a problem.

A. Thank you.

LADY SMITH: What I was saying about the screen is, some people are happy about having it up, showing all the time. If at any time you want it switched off, just tell me and we can do that.

A. Okay.

LADY SMITH: Also, if at any time you have any questions, you speak up, just like you have just done now, volunteer anything that matters to you because I want to hear it. If you need a break at any time, you just tell me. That's not a problem. If it works for you, it will work for me.

A. Can I just -- sorry for interrupting. If I look as if I'm having a stroke or a seizure, please ignore it. It's not, it's just part of my condition. So there's no need for medical intervention.

LADY SMITH: Okay, that's fine. If you do think you need help, you just ask for that, 'Katniss'.

A. Okay.

LADY SMITH: Otherwise, anything else that I haven't thought of that we might be able to do to help you give your evidence as clearly and comfortably as you can, you just let me know. The key is that we want to help you give the best evidence that you can about everything that you feel able to tell us, and I hope by the end of the session we'll do that; all right?

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 morning, 'Katniss'.

A. Morning.

Q. I'm going to do something quite formal first of all, and just ask you to look at the last page of your statement. I think it's open there in front of you.

A. Uh-huh.

Q. The statement has a reference, WIT-1-000000824 and, at paragraph 161, 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.'

And we can see that you signed the statement on 6 October 2021; is that right?

A. I did.

Q. Now, I know, and I'm going to come to it straightaway, that if we go back to the start of your statement, since signing the statement, you have found out some further information which we'll come back to just very shortly.

We can see, at paragraph 1, that you were born in 1971. If we go to paragraph 2, at the time that you signed this statement, in 2021, you gave us your understanding of your life before going into care. I think, since you signed this statement, you got some access to records and you've discovered that maybe what you've been told about your life before care wasn't what had actually happened; is that right?

A. Exactly.

Q. Can you tell us a bit about what you now understand about your life before care?

A. My life in care started in, I believe, [redacted] 1973.

Sorry, [redacted], I think it was. My mother fell pregnant with me at the age of 15 and when I refer to my mother carrying me, she was a baby having a baby. Had me at 16. And as a result, she ended up developing postpartum and that went undiagnosed. And I don't believe that she was given a proper diagnosis as an adult either.

Erm, we went and lived in Barrhead with my grandfather. At the age of -- my mother was 18 and I -- her name's [redacted]. And I was two, two-and-a-half. I would have been two, and my grandfather decided to kick us out because the system at the time basically said my mother had behavioural issues. No, she didn't. She had postpartum and God knows what else she suffered after me.

Erm, so it's not only my story and experience I've got to tell; I've got to tell my mother's story as well.

Erm, Carsewood was my first home. And back then it was -- there were no men in the care system at all, very few.

LADY SMITH: Sorry to interrupt, 'Katniss', you are talking about Carsewood Children's Home?

A. Uh-huh.

MS INNES: Did you move -- sorry to interrupt as well. You moved from your grandfather -- you said your grandfather

had kicked you and your mother out --

A. And as a result of that, I was snatched off my mother by, erm, at the time, Strathclyde Social Work Services and placed in the care of Carsewood Children's Home in Hillfoot Drive, Howwood. Secondary Institutions - to be published later

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[redacted] And, erm, it was recently, erm, while working with my solicitor, Kim Leslie, that I discovered, my mother. That's where I found this info, that my mother didn't abandon me. [redacted]

And as part of my healing journey, I was getting my birth certificate for something and I thought: 'Well, I'm at the records office, I'll see if I can trace down my mother's'.

And I found out that she committed suicide by drug overdose, and I believe that is due to undiagnosed

mental health issues, which then helped me to understand a little about my own medical history surrounding family.

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The rest of the family, they were okay-ish. They talked to me, but then my gran -- when it came to my grandfather, when I spoke to him, he wasn't really -- he was more interested in what was happening at the back of him than wanting to make facial contact. And then I realised with this little bit in my records that he was a coward, erm, because my mother was a young -- the youngest girl, erm, and yet he kicked her and I out, but allowed his working kids, kids who had jobs, to stay in the house.

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[redacted]

MS INNES: So, 'Katniss', you then moved, as you say, to Carsewood Children's Home and you tell us --

[redacted]

Q. And we know that there came a point -- if we move on to page 9 of your statement, and paragraph 42, while you were at Carsewood, there came a point when you were put to Ladyfield. Now, do you have any idea why you went to Ladyfield?

A. To this day, no.

Q. So even though you talked about the work that Kim Leslie did in getting your records and speaking to you about some things that you hadn't known about before, you've

never been able to discover what -- why you went there?
A. No.
Q. Okay.
A. But I will say I was used as a guinea pig for loads of drugs for ADHD, to the point where I ended up being hospitalised in the Queen Mother's Hospital, in Glasgow, due to an awful reaction towards Ritalin.
Q. Was it after that reaction that you went to Ladyfield?
A. Mm-hmm.
Q. And when you went to Ladyfield, you tell us that you were there for nearly two years, I think. And --
A. Yeah.
Q. -- you were staying there during the week and then going back to Carsewood at the weekends?
A. Yeah.
Q. Do you know why there was that arrangement?
A. Because looking at it from adult, it was my legal address.
Q. Did any of the other children leave Ladyfield at the weekends when you were there? Can you remember?
A. Yeah. Erm, I can't remember her name, but I do know that she went back to her family in Cumbernauld, and there were several other kids who went away, got picked up by their family. And I was picked up by a driver with -- in a van with Strathclyde Regional Council

emblazoned all over it, so people knew that exactly I wasn't going to mum and dad's. I was going from one institution to another.

Q. And were you picked up on your own and taken back?

A. Not on my own.

Q. And then, presumably, were you taken back on a Sunday night or a Monday morning?

A. Monday.

Q. Monday morning. Okay.

Q. If we move on to the top of the next page, you talk about -- that's the allergic reaction to the Ritalin that you referred to?

A. Mm-hmm.

Q. And you say that you think that you were maybe

sectioned, or at least that's what you believe?

A. That's what I believe.

Q. Why do you believe that?

A. Because if you're under a mental health section, you're only allowed out on the grounds and then I had a psychiatric unit. And I've been in many psychiatric units from the West Country, in Weston-super-Mare, up to, erm, Dykebar, in Paisley. I've been in quite a few in -- a couple of them I've been sectioned in.

And when you're on a section, you're not allowed to leave the hospital grounds.

Q. And it was the same at Ladyfield?

A. Mm-hmm.

Q. So looking back as an adult, your reflection is the same circumstances happened at Ladyfield, so that's what it was like?

A. The only time you got into town was to the open air market on a Saturday, and that was under the supervision of the nurses and you weren't allowed out their sight. And, erm ... and I believed the town knew who we were and where we were from because of that.

Q. The other thing that you say in this paragraph, 'Katniss', is as an adult, you think that you were sent to Ladyfield 'to be out of sight and out of mind'?

A. I still believe that.

Q. And then you go on to talk about Ladyfield itself, the building and what it was like. Can you tell us a bit about the building that you were in and the grounds?

A. For those who haven't been institutionalised -- and I hope you weren't -- it doesn't matter if the institution is two council houses knocked into one or the size of the former Quarriers Village, you find wee secret places. And I found my wee secret place where I could relax and the garden was massive.

Ladyfield was like a mansion. Long driveway. You know, as I'm talking about this, I can smell the dirt. I can actually smell it.

LADY SMITH: 'Katniss', what was it you said you could smell?

A. As I'm describing the garden, I can smell the soil, the plants.

LADY SMITH: This is the outdoors?

A. Yeah, this was my escape. In front of Ladyfield, there was this beautiful green and it was a circle -- it was circular.

And one of my safe spaces was -- we were talking about this, [redacted] and I were talking about this on Monday, that there was this beautiful monkey puzzle tree, and it's funny how everybody mentions that monkey puzzle tree.

LADY SMITH: They're very striking.

A. Oh, they're stunning. And in Dumfries back then we had a storm and it was a bad one and my tree got destroyed, and it broke my heart, so I had to find somewhere else safe, erm ...

LADY SMITH: Where did you go?

A. There were -- a field at the back, separated by a fence and there were rhododendrons. They're stunning as plants. And then as an adult I got into gardening and realised that they were a nuisance, but I still love them.

LADY SMITH: Depends whether you're talking about the ones that just grow wild or the ones that are specially cultivated. The purple ones you're thinking about?

A. Yeah.

LADY SMITH: They do get a bit out of control in the --

A. To me, they're as bad as Japanese knotweed.

And it's ... and then there were wee places you could go where people wouldn't see you, despite that's where the playground was and the -- at the back. I had everything, erm, including a hand-built fort, with a platform up the top. And on rainy days I used to go in there.

But, also, outside in the garden, that's when I started to self-harm. I've got two scars on my legs.

One is covered up with a bleeding rose in memory of my mother.

LADY SMITH: That's a tattoo?

A. Yeah. The other is Medusa, to show the world that I survived rape and sexual violence. And I've got one other scar, and it's when I jumped off a tree [redacted] but I misjudged.

MS INNES: I think that happened at Ladyfield, 'Katniss'?

A. Ladyfield, yeah.

Q. And after that happened; was there a follow-up to that? Did people talk to you about why you had done that?

A. No. I know there's a -- my community is hitting the headlines all for the wrong reasons and for all the misinformation out there, with the Supreme Court ruling of what is a woman.

I knew there was something different about me when I was in Carsewood. And I noticed my body was stranger than most, [redacted]

[redacted]

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Q. And during the time you were at Ladyfield, even apart from that incident, over that nearly two-year period; was there any discussion --

A. About my gender dysmorphia? No.

Q. Okay. What impact do you think that lack of discussion had on your later life? (Pause)

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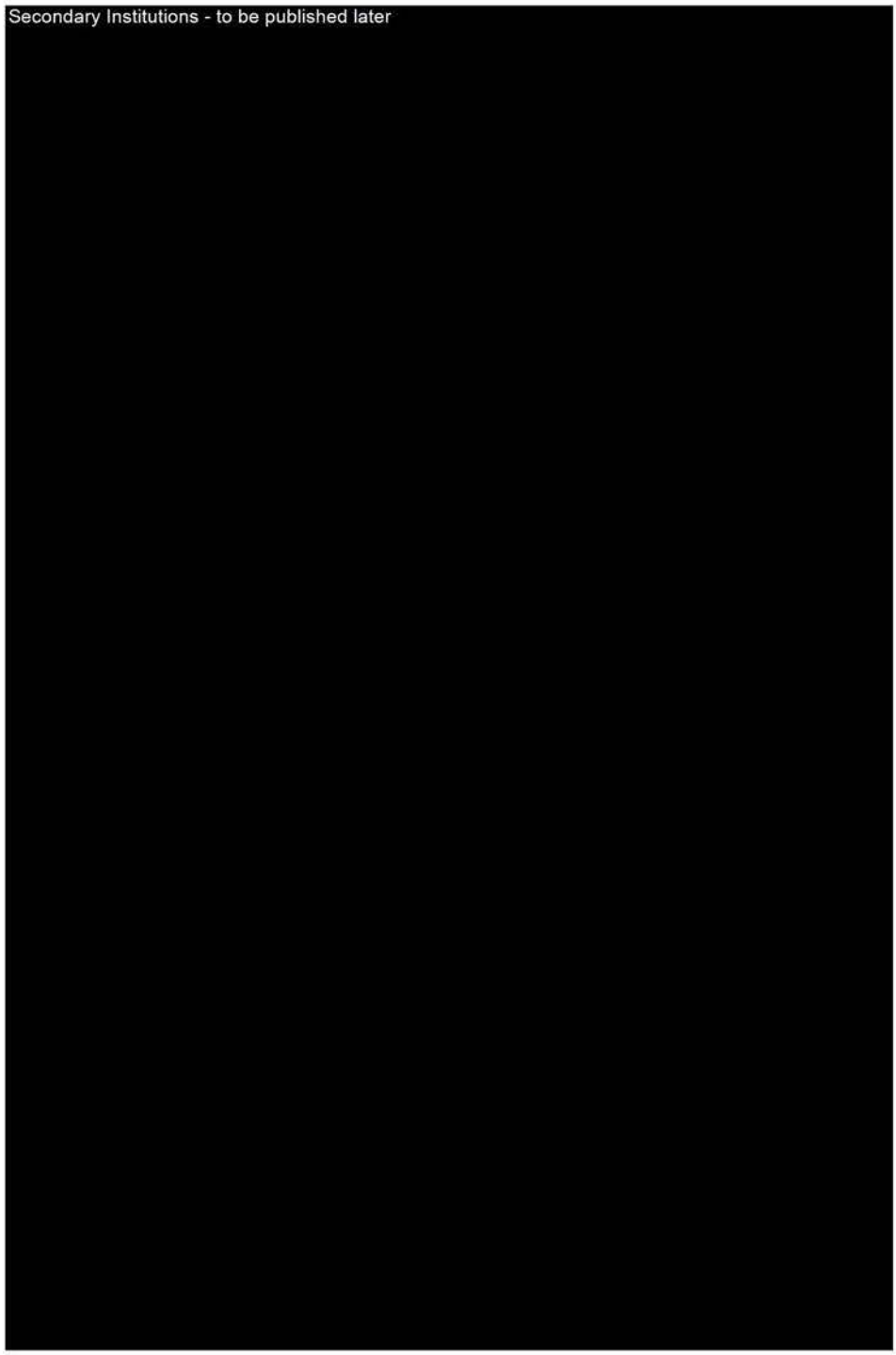
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And then I went to Gryffe Home temporarily from there, Secondary Institutions - to be published later

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[redacted]

Q. Now, I'm going to take you back again to Ladyfield, if that's okay, 'Katniss', and ask you some other questions arising from your statement.

If we look at page 10 and paragraph 48, you talk about washing and bathing at Ladyfield. You say that it was all communal showers and baths, so if someone was having a bath, you could be in there brushing your teeth.

What did you feel at Ladyfield about privacy or the lack of privacy that there was?

A. I'm going to paint you a picture using Carsewood and Ladyfield.

Carsewood was a big building built in the sixties. And I think it had more kids than Ladyfield had patients. I'm not going to call myself a resident because you're not a resident in a hospital; you're a patient.

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[redacted]

[redacted]

Ladyfield, the bath -- baths, sorry, showers, were in the same place as the sinks for washing your hands and brushing your teeth and washing your face, and, erm, you had both male and female nurses supervising. I'm thinking -- today as an adult, I'm thinking if I found out that was happening, I would go absolutely bat shit crazy that a man was able and allowed to watch a girl shower, bath.

Q. [redacted]

A. But no privacy in Ladyfield.

Q. Okay. If we can go on over the page in your statement, please, to page 11, and paragraph 49, you talk about the grounds at Ladyfield and being able to stay within the grounds. You've already told us about that.

But you then say:

'If you went out of the grounds you got disciplined. I remember leaving the grounds and going to a walled garden not far from the hospital. I was made to wear my pyjamas and stay in bed.'

A. Mm-hmm.

Q. So was the wearing pyjamas and staying in bed

a consequence of the fact that you had gone to the walled garden?

A. Yeah.

Q. How did you feel about that? How did you feel about the consequence of wearing pyjamas?

A. Humiliated, degraded. What purpose to this that -- what was the purpose?

Q. How long did this last for, that you were made to wear your pyjamas and stay in bed? Was it that evening or did it go on for longer than that?

A. The longest I had to stay in my pyjamas was a week.

Q. And were you going to the school at Ladyfield?

A. Yeah.

Q. And what were you doing? Were you still able to go to school when you were wearing the pyjamas?

A. They wouldn't let you put the outdoor clothes on. That was all part of the humiliation.

Q. So you would go to the school in your pyjamas?

A. Uh-huh.

Q. Then, when it was break time or after school; did you have to stay in your bed or were you able to move about? Can you remember?

A. While you were in your pyjamas, you weren't allowed to have fun, you were separated. You were segregated.

Q. When you say you were segregated; were you put to

a separate bedroom or did you remain in your own bedroom, but the other --

A. My own bedroom.

Q. -- the other children that were there; were they often doing their normal --

A. They were outside playing while I was in my bed. 'Cause my bedroom was at the front of the building. So any time I had a rough night or I couldn't sleep, I knew I had my monkey puzzle to look out to.

Q. If we look on to the next paragraph, paragraph 50, you talk about -- we have just mentioned school at Ladyfield. You say you weren't diagnosed with dyslexia until you were older?

A. No.

Q. How did you get on at school at Ladyfield? Were you going there every day during the day for normal school hours or not?

A. I'm going to sum up my education in one sentence: from primary right until I couldn't stand it any more, I wasn't given an education. Strathclyde Council couldn't give a shit. They wrote me off, just like they wrote my mother off. Just like they wrote off thousands of other kids in my generation.

MS INNES: Can I ask you -- sorry --

A. I left school with no qualifications. My diagnosis for

my dyslexia was by a psychologist employed by Weston-super-Mare's psychiatric unit in north Somerset, at the age of 20. So up until that time, I had no fucking clue how to write my dead name. I knew how to say it, but you could have put it in front of me and I would say: 'What the fuck's that?'.

Q. Now, before I go on over the page, there was another matter that I wanted to ask you about and that's bed wetting. And when you were in care; was this something that happened to you?

A. Every night. Every night.

Q. And did it happen at Ladyfield?

A. Absolutely.

Q. And what was the reaction of the staff at Ladyfield to that happening?

A. I got ridiculed.

Q. Ridiculed by staff or by other children?

A. Mainly staff.

Q. And after you left care; did that continue to happen or not?

A. [redacted] Johnstone was my very first flat and I went to my bed that night worried if I would wake up to a dry bed or a wet bed.

And you know something? From the day I left the care system was the last time I wet my bed, apart from

in a blackout with alcohol, which was very rare. So you're an educated woman, do the math.

Q. Okay. If we can go on over the page, please, to paragraph 55 of your statement, you tell us here about something that happened in a service tunnel at Ladyfield. Can you tell us about that, please?

A. Oh, yeah, I can. For some reason, I was punished and told to keep the door open, for no reason, in the service tunnel, and I was there for hours.

Q. On your own?

A. On my own.

Q. You say if you moved away from there, you would be battered by the nurses?

A. Uh-huh.

Q. When you say 'battered', what do you mean?

A. Punched in the stomach so hard that I would be winded, erm, threatened to have needles put into me if I didn't behave. Who the fuck says that to a child?

Who in their right fucking mind threatens a child to stab them with a needle to get them to comply?

These nurses took an oath to care and do no harm. That's why I very rarely refer to them as nurses because they do not live up to what a nurse is. A nurse is supposed to be caring. A nurse is supposed to be healing.

Q. You say there that you were injected with an empty needle?
A. Mm-hmm.
Q. How did you know it was empty?
A. Because I was in the room when they were so-called preparing it. I was in where you got your medication, where you got your Smarties to keep you quiet.
Q. Were there times when you were injected with something, not an empty needle, but with a drug, when you were in Ladyfield? Can you remember?
A. I've no idea what they were doing. But I do remember getting injected, getting pinned down on the stairs going up to the rooms in the attic, 'cause there were consultation rooms in the attic. And this staircase was creaky as fuck.
Q. You say, at paragraph 57, that you remember being pinned down on the staircase?
A. Mm-hmm.
Q. How many staff members were pinning you down?
A. Quite a few, quite a few.
Q. Do you have any idea why that happened?
A. Because they're sadistic bastards, that's why. Give somebody a little bit of power, you can generally tell who the good ones are and who the bad ones are, and the health board were full of arseholes.

Q. At paragraph 58, you say there that you never reported any of the abuse at Ladyfield at the time that you were there; did you ever report it afterwards?
A. No, because I was -- still wouldn't be believed. Who would believe a kid in care over people who were educated and who were qualified? Come off it.
Q. Who told you that you wouldn't be believed?
A. The employees in Ladyfield. [redacted] As did the staff in Balrossie. [redacted] [redacted] Do you want me to go on?
Q. Okay, so from what you're saying, you say that staff told you you wouldn't be believed; was there anybody other than staff members who you could talk to about what was happening at Ladyfield?
A. Nobody.
Q. Do you think it would have made a difference if there had been somebody external that you could have spoken to?
A. No, because they would have been part of the system. They would have been appointed by the very system that was -- who were the abusers.
LADY SMITH: 'Katniss', can you tell me a little bit more about this tunnel, the service tunnel, such as where it was, what it was like?
A. That's where the food got delivered to -- where the

supplies, the laundry -- 'cause the laundry didn't done in Ladyfield; it were done in the laundries in Crichton Royal.

LADY SMITH: So was it at ground level or basement?

A. Basement.

LADY SMITH: Basement level.

A. 'Cause, if I remember correctly, the bathrooms were in the basement. Then some of the bedrooms -- in fact I think all the bedrooms and the living room was on ground level.

LADY SMITH: Okay.

A. And then -- and the ground level was also where you went and got your medication. And then you had the attic rooms, which were consultation rooms.

LADY SMITH: But this service tunnel, you think, was in a basement level?

A. It was in the gunnels.

LADY SMITH: If it was for laundry to go in and out, and food supplies to come in, that would probably make sense --

A. If it was a mansion, it's where the people would of -- the lower classes would of been only allowed to access.

LADY SMITH: Thank you. Ms Innes.

MS INNES: Thank you, my Lady.

Now, I want to take you on to some other matters in

your statement, 'Katniss', and to something that you mentioned a moment ago about people having power.

If we move on to page 27 and paragraph 129, you are talking there about impact. But, at the end of that paragraph, you say:

'The definition of care to me is to look after the most vulnerable in society and not to abuse that power of care.'

Can you explain a bit more to us about what you mean about the power of care?

A. As a child ... as you grow up as a child, you're supposed to be nurtured. You're supposed to be cherished. You're supposed to be encouraged. And I believe the first four years of a child's life is the most fundamental of any human being's developmental capabilities, and I don't care if that's a kid in care or somebody in one of these houses in Cramond, a child's a child.

It doesn't matter if you're getting a primary education in -- let's say Broughton Primary or St Aloysius private school in Glasgow. The first four years of a child is very important.

The system tried to fucking destroy me at every possibility. I had option -- I had the opportunity to learn a musical instrument at primary. I was given the

permission slip to get signed and I was denied that opportunity. An opportunity for me to be adopted was sabotaged. [redacted] and [redacted], they had their own business, lived in Ralston. And I can truly say that was only the time -- and they were in my life for that short space of time -- I actually felt what love and compassion is meant to feel like. And I was told by the social work not to call them mum and dad. I was told to call them uncle and aunt, despite them not being my uncle or aunt. That was the done thing in the seventies. Probably the sixties as well. And the fifties. Until we got into the forties, where the care system is more or less prisons like the Magdalene laundries, yeah.

I slipped up and I called [redacted] 'mum' for the first time and I called [redacted] 'dad'. I believe that if that adoption wasn't sabotaged, I would have been a different person due to getting that care and management, and encouragement and moulding, erm, a child should receive. And unfortunately for me, my son, [redacted], who I have nothing to do with because I chose my drugs, is also a victim of the care system. Not because they're in care; they're with their mum. But because of the direct result of what was done to me in the care system and the medical.

Q. Could we --

A. And God knows what other kids your health board traumatised in the other three places you had. But, by God, hell has got a special place for you. Hell has got a special place for you and I hope you suffer.

Putting children through that is atrocious. It's the lowest of the low. I can show you the scars, but you won't -- you'll look away.

MS INNES: 'Katniss', can I ask you, please, to look at page 32 and paragraph 153 of your statement, where you talk about a matter that you have just mentioned, about not being protected --

A. Sorry, I'm not finished with what care is.

Q. Okay, we'll come back to -- so we were -- I asked you a question about the power of care and I think you were --

A. I'm going to give you the perfect definition of care.

Q. Okay.

A. I'm not originally from this beautiful city, but I'm damn proud to call it my home today. 16 years ago -- and this is what -- you asked me a question: what is care? And: what can the effects of the right form of care have on somebody's life?

There were an -- a charity called [redacted] and we hired out the -- they had the use of [redacted], along [redacted]. For those who don't know Edinburgh,

that's the church with the [redacted] flag on the flag pole. And I was a chef at that place and I was also the chef at the second venue we had to move to due to renovation work. And it was an honour and a privilege to give up my whole Saturday to make sure that these people sleeping rough in B&Bs and hostels -- which I've been in many -- had food in their belly, had a hot drink, somewhere to go where they're not getting judged for who they are and what their background is. And that there is what love, compassion, to me, is.

And every so often, even although the place isn't there anymore -- it folded after I left -- occasionally, when I'm out in the city, walking -- and this is what positive impact can do to somebody's life, adults not children. I'll hear my name getting shouted, "HPY [redacted], we miss your fucking food", "HPY [redacted], we wish you were still doing it, because you're the only fucking person who didn't judge us", because who the fuck am I to judge, when I'm pointing the finger at them and they're pointing back to me? That is love and compassion.

And every time I hear my name getting shouted and that said to me all these years, I'm not qualified. I've not got a PhD. I'm not a social worker. I wouldn't want to be.

I definitely wouldn't want to be a nurse or part of the medical profession because, believe me, Glasgow City -- your health board ain't innocent either. [redacted] So, for me, if you treat people with respect and dignity, despite whether they're still on the streets, whether they're up at Hunter Square drinking, and the closes, jagging up, at least I've moulded these people's lives in a positive way.

I use the term, when it comes to the institutions, 'care' loosely.

So my education is self-taught. I learnt to read as a result of the psychologists of Weston-super-Mare. I went back to college, and, erm, I know it's strange that I didn't want to take the religious oath. But while I was on the streets in Edinburgh, I was two and half years into training as [redacted] priest and then I thought no. So my education is from the streets up.

So that's what care is. That's not what care is.

Q. Can I take you to paragraph 153 now, where you say that you just want it acknowledged that you weren't protected and cherished as a child should have been? You want it on record.

A. Absolutely.

Q. Is that an acknowledgement that you still seek, that you're still looking for or have you received that?

A. I don't quite care about myself. But when I was going through the legal case with Kim and my legal team,erm, thing I did say: 'I hope in 50 years' time I'm not back here again, by God, I hope not, because this would have been for nothing'.

The hundreds of victims from Quarriers, Secondary Institutions Kerelaw, Ladyfield East/West, probably The Kibble, Secondary Institutions - to be published Balrossie, where I was used as a punchbag every day, their suicides will be for nothing.

Do you know what I read most of online? Is the amount of victims. And I wasn't in this home, Secondary Institu Secondary Institutions - to be published worked in this home -- was Kerelaw. The amount of people I've heard on TikTok have ended up committing suicide as adults is fucking atrocious. And if this doesn't change anything and we're back here in 50 years, shame on Scotland because it's a bad day when a streaming service called Netflix has devoted a whole programme to Kerelaw Approved School. It wasn't a children's home; it was an approved school. It was a secure unit. As was Muirfield in Johnstone.

But to be acknowledged and believed, Lady Smith,

I want to thank you for the honour and privilege of coming in and sharing my story.

LADY SMITH: It's fine.

A. And, erm, by God, Strathclyde Regional Council tried to fucking kill me. In fact, they nearly did.

[redacted]

And that's what brought me here today, because I was sitting at home, watching the evening news, when you yourself, Lady Smith, were appealing for residents to come forward [redacted] I'm one of these children in adult form.

LADY SMITH: I see.

A. I'm one of the adult survivors. I'm one of the lucky people here today. Yeah, I'm still angry as fuck and I've got every fucking right to be. But the difference between me and them is, as we say in Scotland, I choose to be a good cunt and not an evil one.

And the one thing I am sick and fed up with is the professional system telling people that somebody in my background, who's been abused, been a bed wetter, been raped, ends up becoming the abuser in later life. That's gobshite. That's a sad excuse for a human being.

That is a sad excuse for a human being.

MS INNES: I think you tell us about that in your statement,

'Katniss', and I know that you feel strongly that that sort of line of argument, if you like, should cease. And we have got that in your statement.

A. You saw me come in here with a stick, this. And I want you to have a good look at this. You're Dumfries, aren't you? Have a good look. Have you got it in your head? Acknowledge me at least. This is what your staff done to me.

I have post-traumatic stress disorder for what your employees done to me and Strathclyde Regional Councils and Inver, Ayrshire. I have something called FND and, as medical, you'll know it stands for functional and neurological disorder.

My PTSD wasn't done through service in the military or serving in the emergency services. My FND is a direct result of your former employees' behaviour, and I want you to look and meet me in the face, and tonight I want my face to be the last thing youse two see as you close your eyes tonight.

Q. 'Katniss' --

A. So this is what the years of abuse has done to me. I knew my mental health would have been fucked up. But little did I realise my physical health would be completely screwed, because up until my body started not working properly, I had a great way of relaxing, and

that was out swimming a mile every day. That's been taken away from me. Thank you. I hope you're proud.

MS INNES: So 'Katniss', we have your statement, as you know, in addition to the evidence that you have given today and all of that will be taken into account by the Inquiry. But I don't have any more questions for you just now. Thank you.

LADY SMITH: Thank you.

I don't have any more questions either 'Katniss'. I just want to thank you again for taking the trouble to come here today and to talk about your evidence in more detail than we already have from you in writing. Do remember I have everything about the other places that you gave me written evidence about, too.

A. Can I just say though, HGE and zGVW 's other victim, they didn't live to see justice, so I'm thinking about him today. Even though it's not Balrossie, but it's Ladyfield, I'm still here to tell his story and countless others who aren't here today.

LADY SMITH: Thank you for that, 'Katniss'. I'm sure it's carefully noted.

You are now free to go.

A. Thank you.

Remember my face.

Thanks, Lady Smith.

LADY SMITH: Just take your time and take care.

(The witness withdrew)

LADY SMITH: Well, I'm going to rise now for the morning break. The plan next is what?

MS INNES: It's likely that we'll start after 12 o'clock. But perhaps if we just alert people attending when we're ready to start again.

LADY SMITH: I think that would be best. Thank you.

(11.26 am)

(A short break)

(12.23 pm)

LADY SMITH: We move now to the next witness and this is 'Thea', I think, Ms Innes, is it?

MS INNES: That's correct, my Lady.

She was initially admitted to Ladyfield on [redacted] 1995 and discharged on [redacted] 1996. She was then admitted for a second time on [redacted] 1997 and discharged on [redacted] 1997.

I'm just going to give reference to her statement now. Her statement is to be found at WIT-1-000001228. And 'Thea' signed her statement on 27 March 2023.

LADY SMITH: Thank you very much.

Now, some of you here may remember on previous occasions we've had witnesses who are giving evidence from behind a screen and this is one such witness. So

what will happen very soon is, a curtain will be drawn across the whole room and also around where the witness will sit. 'Thea' will come in and make herself comfortable, and the curtain that's right across the room will then be opened again. That's the short version. It takes a bit of moving around, but we'll do it as efficiently as we can.

(Pause)

'Thea', welcome. Thank you for coming. Before we get to your evidence, let me explain -- I think it has already been explained to you, but I want to tell you myself -- the curved curtain that's been pulled round means you are now behind a screen. So the only people that can see you are the two women who are sitting with you, Ms Innes, there will be somebody on the desk over here and I think you have already met the young woman who is going to be there, and me and the stenographers.

We will move in a moment to opening the curtains that go right across the room. That's because I need to see the people that are out there and they need to see me, but they will only be able to see me and Ms Innes. Does that all make sense?

A. Yeah.

LADY SMITH: If you've any worries about that at any time, please just tell me.

So if we can move to opening the curtains that go across the room.

(Pause)

Let me now move to the next stage. I understand that so as to promise to tell the truth, you would like to do what we call affirm, rather than swear an oath.

'Thea' (affirmed)

LADY SMITH: Now, we're just about to move to the matter of your evidence and it will be Ms Innes who is going to ask you some questions.

Now, as I say to all people who come to give evidence here, I really want to do what we can to help them give the best evidence they can, whatever it is they're here to talk about. I know that you're here to talk about your childhood and some very distressing and difficult aspects of your childhood. I understand that.

I understand that it may be upsetting. If you want to stop at any time, just say. If you want to have a break, or if you don't feel you can deal with any of the questions, that's quite all right. You do what you can and what feels right for you; do you understand that? Is that okay?

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

Ms Innes.

MS INNES: Thank you, my Lady.

Now, 'Thea', we know that you were born in 1980 and that you went to Ladyfield in 1994; is that right?

A. Yeah.

Q. Do you know --

LADY SMITH: Sorry, I'm going to interrupt just a moment, and maybe somebody can help with this. I think we need you a little bit closer to the microphone. I want to make sure I hear everything you say, because it's important to me. As you know, the stenographers are keeping a record and it helps them to hear through their headphones if you're in a good position for the microphone. That looks a bit better.

Ms Innes.

MS INNES: Thank you.

So we know that you went to Ladyfield in 1994; do you know why it was that you went to Ladyfield?

A. Yeah, eating disorder.

Q. You had an eating disorder. And when you went into Ladyfield; did you get treatment for your eating disorder? Can you remember?

A. Yeah. Erm, I mean, it was mostly just trying to get my weight up and eat enough. That was the point: to get weighed and gain weight.

Q. Get weighed and gain weight. Did you have any therapy around that? Can you remember?
A. Not really. Erm, it was just gain weight, and I think that was it.
Q. Okay. Now, are you able to tell us a little bit about the part of Ladyfield that you stayed in?

We know that there are different bits of Ladyfield; are you able to describe what you remember it being like?
A. It's like a big house. There was two Ladyfields; there was Ladyfield West and Ladyfield East. Erm, the one that I was in, it was like a big -- kind of like a big house, or -- it's pink in colour, like from -- that's how it looks from the outside. And it had like a big room, it was like a living room. And the bedrooms were upstairs and there was a school bit attached. But it wasn't the same as the rest of the building; it was a different -- it looked like a big corridor, but it wasn't. It had classrooms and stuff, but I wasn't in it, ever.
Q. So was it a completely separate building, where the school was?
A. No, it was attached. But I wasn't ever in it, so ...
Q. And you mentioned there was Ladyfield East and West, and you described a building that was pink on the outside;

was that Ladyfield East or West?

A. It was East.

Q. East?

A. Yeah, that's the one I was in. Yeah, Ladyfield East.

Q. And you mentioned there being bedrooms upstairs; did you have a room of your own or did you share a room?

A. They were shared.

Q. How many people were in the rooms?

A. The first one I was in had, I think, it was three girls, but it might have been four and the next one had just two girls.

Q. So when you say 'the next one'; is that when you went back to Ladyfield later on or was that the first time that you went?

A. That's the first time.

Q. So the first time that you went, you didn't stay in the same room all the time?

A. Got moved, like. Then I shared a room with another girl who had an eating disorder, too.

Q. And how -- can you remember roughly how many patients were in the building?

A. I don't know. There was, like, boys at one side, their bedrooms were at one side and girls at the other side. We weren't in the same -- like boys had their own sort of side of the -- where the bedrooms are and there was,

like, a room in the middle, at the front of the building. That's where the staff were at nighttime.

Q. Okay. Now, you mentioned the staff there; were there staff at Ladyfield that you liked and got on with?

A. Erm, yeah. The doctor that was kind of -- she was a younger doctor that -- she admitted, like, for the eating disorder stuff. Like, her name -- she was really good and most of the nurses were -- erm, like, they were really nice and, yeah, I mean, I didn't really -- there was not one that was a favourite one, but most were just all right and they did their jobs. You know, yeah, but the one doctor that was good -- I don't know, shall I say her name or?

Q. It's fine to say her name, yes.

A. Her name's Sarah, like her first name.

Q. Her first name was Sarah?

A. I know her second name, too, because it was Huken and there was two older psychiatrists who were married to each other, that worked there, too. But I didn't really see them much.

Q. Okay, so you didn't see the couple? There was a couple --

A. I did see them, but not very often.

Q. Okay. You saw the younger doctor?

A. Mm-hmm.

Q. You've also told us in your statement that there was a cleaner, I think, that had a positive impact on you?
A. Yeah, yeah.
Q. Can you tell us about the cleaner?
A. She was quite young, but she was -- she seemed older than she was. Like, she didn't look old, but just the way that she was, she seemed -- you know, she was just helpful. Like she -- you know, she chatted and she didn't do therapy, obviously. But it kind of was therapy the way that she -- well, you know, just the way she -- it wasn't just me, but with everyone that was there. She just chatted to people and kept us kind of sane. She was probably the most -- person that gave us most therapy.
LADY SMITH: Did she chat to you while she was getting on with her work, 'Thea'?
A. Yeah, yeah.
LADY SMITH: So it was just ordinary life?
A. Yeah. She didn't -- she wasn't -- she was friendly, like she could have been a friend 'cause she wasn't much older than a lot of us. You know, she was kinda -- she was older, obviously, but she wasn't that much older. Yeah, she was -- she probably was, like, the best therapist in there.
MS INNES: Now, you tell us a little bit about the morning

routine. One of the things that you mention is that there was a morning meeting; what was the point of the morning meeting?

A. I don't know really. It was just like a big room where -- you know, we're all sitting in chairs and, I don't know, I think it was just to talk about how we were feeling and what -- I don't really know the point of it. But, you know, everyone in the unit did it, like we all had to take a turn and say -- I don't really know what the point was. It just -- I remember there was a girl who sat and told everyone that she'd [redacted] overdosed, and that's why she was put in there, and stuff like that that people just talked about, but I don't really know what the point was, though.

Q. And how did you feel about going to meetings like that?

A. I hated it.

Q. What was it that made you hate it, do you think?

A. Because it was embarrassing, sitting in a big room with people and I didn't know what to say.

Q. Was there a meeting in the evening as well or not?

A. I don't remember. There maybe was. I don't remember.

Q. Okay. Now, you mentioned school a moment ago. You said, I think, that you didn't go to school while you were in the unit; no?

A. No. I mean, if I did, it would have been like, you know, probably three or four days. But, you know, if I did, I don't remember going.

I do remember the two teachers that were there, 'cause they came to meetings, too, sometimes. And they were nice, but I didn't really know them.

Q. Okay. In terms of your bedroom, you mentioned that you were in one room and moved to another; did you have, you know, your own belongings with you or not?

A. I can't remember.

Q. How did you get on with the other children who were there at the time?

A. Okay. It was -- there were girls that had, like, I think before the girl -- I shared, sort of two people. Like, the other girls -- some of them were mostly, I think, they were from England. Like, they had different stuff going on. You know, mostly overdoses and, like, cutting and stuff. That's what most -- that kind of was the biggest things for them, and I think they were all in care and stuff before.

Q. So you say they were all in care, were they?

A. I don't know if they -- I just guessed that most of them were. But I don't know for sure, just from what I remember.

Q. And while you were in Ladyfield; did you have any

contact with people from outside Ladyfield or were you just there the whole time?

A. Not really. Not really.

Q. Now, I want to move on and ask you about what happened to you in Ladyfield, if you feel able to talk to us about that.

You've told us in your statement that things happened; what are you able to tell us about just now?

A. I don't really know -- I don't understand the question, really.

Q. You talk about abuse that happened in Ladyfield and you talk about a particular member of staff who abused you in Ladyfield; are you able to tell us anything about that just now?

A. Erm, it was ... birthday and I was out that night for -- I don't know, it's the first time, I think, since I was admitted. I don't know. And walked to a shop that was -- it was kind of far way, but not that far, and got [redacted]. Not anything illegal, just [redacted] and Diet Coke and took them on the way back to the unit. And I thought I would die that night. Like, I thought I would just go to sleep and I would die. But I didn't know that's not what happens with overdoses.

And, yeah, when I got in, I was really sick. It wasn't like I went in straightaway. But I don't know

how long it was. But I thought I was just going to go and die, like, as soon as I got in. Like, and no one would know what I'd done.

And, yeah, it didn't work that way.

Q. Are you able to tell us what happened next?

A. I don't know what happened straight after. I know I went to bed and there was another girl in the room, like, that shared that room with me. And I don't know when I started, like, thinking I was going to be sick, but I know I was sick. Like, it did -- like, not in the bedroom, but in the bathroom. And, like, because the staff were upstairs at nighttime, like, they kind of obviously noticed and I wasn't really meant to be going to the bathroom, like, by myself because eating disorder stuff and, like, cutting stuff.

And, like, you know, he came through to check on me and I don't know how many times he came to check on me. I know one of the times he -- it wasn't just checking on me.

Q. Are you able to tell us what happened on that occasion, when he wasn't just checking on you?

A. Erm, I was -- there was a shower I was just being sick into, and I don't know if it was then or when I was being sick in the toilet. I don't know, I can't remember. But he -- like, he had his arm round me,

like, looking after me, like, I don't know, to keep my head up and stuff. And, erm, my hair was really long then and he -- he was just keeping it out my face and stuff, and then it changed.

I don't really understand. Like, I wasn't looking behind me. I didn't know, really, what was happening and I didn't really care 'cause I was just being sick and I just -- and then I could feel it, I could feel him. I could feel this arm, like, there, like round --

LADY SMITH: You are touching round your neck.

A. It wasn't completely round my neck, it was sort of --

LADY SMITH: Just below it?

A. Yeah, and I thought he was just holding my head up and he -- and he was, but, like, he was close. I could feel him, like, probably too close to be holding a head up. And, like, then I could feel other things that -- I don't even know what I was wearing. I don't know what I was wearing, like, if I had pyjamas or a night -- I don't know. But I could feel, I don't know, this hand like round, like, where my ribs are and just holding me up. And I could feel him, like he wasn't -- like his jeans were not closed. And he used to wear these jumpers that were -- they had this wool that just -- it was awful. Like, his jumpers looked awful and they felt awful.

I don't know how to say it, what happened. I know what happened, but I don't know how to say it.

Q. Okay. So --

LADY SMITH: Don't answer this if you don't feel able to, 'Thea': but have you a memory of feeling some part of him on your skin?

A. Yes.

LADY SMITH: Hands on your skin?

A. It wasn't just hands.

LADY SMITH: Not just his hands.

A. You know, I told you about the hands. Erm, it wasn't just his hands. I knew his jeans were open. I knew that that -- I knew that that -- my -- the bottom part of my body, he had against him and I couldn't move. I don't think I tried to, though. I know I didn't say no to anything that was happening.

MS INNES: You tell us more about that in your statement, 'Thea', and you don't need to go into any more detail just now if you don't feel able to.

So I think you tell us in your statement that he touched you sexually that time, on that occasion?

A. He didn't touch me sexually.

Q. Sorry?

A. He didn't just touch me sexually.

LADY SMITH: I think you said to me 'it wasn't just his

hands'?

A. No.

LADY SMITH: And do you have a memory of his jeans being open?

I've got the picture. You don't need to say any more if you don't want to, 'Thea'.

A. Okay.

MS INNES: Were there other staff members around that night?

A. I don't know who, but there always had to be a man and a woman on at night. And the room that -- 'cause they had a room that they could see into two. There was two bedrooms on either side, and they could see into one of the boys' bedrooms and one of the girls' bedrooms, and I think just to check that people were alive. And so there was always a man and woman. I don't know who the woman was.

Q. Did you see her that night?

A. Probably, but I don't know who she was or -- but I know she didn't come out of that room at that time.

Q. After this happened; was there anybody that you felt that you could tell?

A. No. I know that, like, when -- I remember him hugging me, like, 'cause I was crying. Not in the shower room. But I was crying outside of it and he hugged me and, like, he just -- I don't remember saying anything, but

I remember, like, holding my hair and saying something, sorta looking after me. But I could feel his jumper. I could feel his hands and I didn't really -- I remember thinking: 'I'm going to die anyway'.

And I did think that he cared about me when he hugged me, 'cause he was looking after me. And I still thought I was about to die, so I didn't really mind.

LADY SMITH: When you're talking about thinking you were going to die anyway; have I got you right: that that's going back to the fact that you had [redacted]?

A. Yeah.

LADY SMITH: And although you had been sick, you still thought you'd [redacted]?

A. Yeah. I just didn't understand that -- I thought that if you [redacted], I was going to die and ...

MS INNES: And, after that, the next day, or a bit later after that; was there anybody that you felt that you could speak to about what had happened?

A. No. It took -- I don't know how many -- I know that no one knew about the overdose 'til -- it wasn't straightaway. It was a day or two days, three days after anyone knew about the overdose, 'cause I didn't tell anyone 'cause I still thought I was going to die from it, even though it was taking ages. And I didn't -- I remember we were doing something --

I don't even know who it was I told, 'cause we were doing something in the -- I don't know, the living room floor, and lying there, and I told someone that I should be dead 'cause of what I'd done. And that's when it all -- everyone found out and that's when they took me to the other hospital, the normal hospital, to get checked.

Q. So it was a little while later that you said to somebody about the overdose; did you say that to another patient or was it to a member of staff?

A. I think it was another patient. I think it just ended up that staff knew and then -- I can't remember who I told. It might have been staff. It might have been a patient. I don't know. I told someone.

Q. So it looked like nobody had told the other staff that this had happened during the night, that you had had the overdose?

A. During the night -- I don't know. Maybe he did, because there would have been [redacted], when I was being sick. I don't know what -- 'cause I didn't look. I don't know if -- probably now, like, if I took an overdose now, I would [redacted] when I was being sick. There would have been then.

Q. So, as you said, it was a couple of days after that they took you to the main hospital. Okay.

Now, we understand, I think, that there was a time that you left Ladyfield and you went to another hospital, somewhere else?

A. Mm-hmm.

Q. Okay, and then you went back to Ladyfield, again?

A. Mm-hmm.

Q. I think that was in 1997; is that right?

A. I don't remember.

Q. You don't know. Don't worry about the times.

LADY SMITH: We have got the dates from records. Don't worry about that, 'Thea'. But you'd be a teenager and not newly a teenager, into your teenage years by then.

A. I think I was like -- I think it was, like -- I think it was, like, 16 or something. It wasn't -- 'cause I went into another hospital when I was, like, here, in, like an adult hospital. Like, I went home and then went into -- like, something happened at home and I ended up in an adult hospital.

MS INNES: So when you went back into Ladyfield again; did you initially go to the Crichton?

A. I don't remember.

Q. You don't remember. Do you know why it was that you went back to Ladyfield, again?

A. I can't remember.

Q. Okay. That's fine.

Was anything different this time when you went to Ladyfield or was it much the same?

A. It was -- I think it was a different thing, 'cause I was -- I had a different bedroom. It was like a big room that was just for me.

Q. And was the same person there that you've just spoken about?

A. Erm, I think so. I just didn't really care. I didn't -- 'cause then I just -- they quickly left me to it. You know, if -- I could do what I wanted, really. I know I didn't care if he did anything or if anyone did 'cause by that point I had just completely -- like, so much had happened and I just didn't care.

Q. Did anything happen with this man again the next time that you went into Ladyfield?

A. Yeah.

Q. What happened?

A. Erm, it was -- it only -- there are so many broken up bits I remember. There's one thing that I do remember that's not so broken up, and it was me and another girl, that she was -- she's younger than me, but not that much younger, in a big room with chairs. And, yeah, we both -- we both, erm, did stuff to him -- with him. I don't know how to say it.

Q. That's fine. You don't need to say it.

A. He was working there the second time, yeah.
Q. Okay, and this time, the second time that you were at Ladyfield; did you feel able to tell anyone what was happening or, you know, was there anybody there that you could have spoken to?
A. Probably, but I just didn't care.
Q. Now, if we think about things that you hoped would be different for children and what we should learn from your experience; what sort of things do you think that we can learn from your experience?
A. I don't know now, because I think the things that were there then, people knew and they would have known then what should be done, and it wasn't done. And it's the same now. Everyone knows the rules, but some people don't follow them, do they?
Q. Do you feel that it would have made any difference if there had been somebody who you could have spoken to, somebody who was not part of the hospital, who you could have spoken to?
A. I don't know, 'cause I didn't really think about it and it just didn't happen. So I don't think about if there had been someone there.
MS INNES: Okay, well, I've covered the questions that I wanted to ask you about. Is there anything else that you wanted to say, that you wanted Lady Smith to hear

when you're giving your oral evidence?
A. I don't know. I can't remember. I don't know.
MS INNES: Okay. Well, we have got your statement and we've heard from you in person, so I don't have any more questions for you. Thank you.
LADY SMITH: 'Thea', there's just one thing, if I could trouble you with, if you're able to help me. You said that the second time you were in Ladyfield, you probably could have told somebody about what was happening with this member of staff, the nurse, but you just didn't care.

As you look back now, as an adult; do you know why it was you didn't care?
A. Yeah, erm, because of everything that's happened in between. And there was other places I had been and police had asked about stuff, and the doctors said that it was promiscuous. So I didn't see why anyone would want to know. And I didn't know what that word means until much later, but I knew it wasn't good. So I didn't see the point in telling them anything.
LADY SMITH: So, is it a matter of you probably were thinking: 'There's no point, because nobody's going to listen', or 'Nobody's going to believe me', or both?
A. I knew they believed me, but I knew they didn't care.
LADY SMITH: They didn't care, so nothing would happen?

A. They just -- they didn't -- because that word was used. And I knew what it meant, like, 'cause it got explained to me, I thought: 'Well, everyone thinks that's what I am, anyway, so what's the point in telling anybody? Because they think that I want it and ...

LADY SMITH: But what you've described is a man who was in a position of trust and he shouldn't have exploited that trust; do you realise that now?

A. Erm, sometimes.

LADY SMITH: Well, you are not the only person that I have listened to who's been in that position as well. You probably feel very alone with your past. If it's of any help, you're actually not. I can fully understand what you've been describing to me and I thank you for being able to tell me yourself as much as you have done.

As I said before, I also have your written evidence and the detail that's in that, which is really helpful for the work we're doing here. I'm very grateful to you for having gone to the time, trouble and inconvenience of coming here today, so thank you so much for that. I'm now able to let you leave.

We'll pull the curtain, so that you can get out of the room in the same way as you came in. Nobody out there can see you. Whenever you're ready, do feel free to leave.

(The witness withdrew)

LADY SMITH: Well, Ms Innes, I'll rise now for the lunch break and I'll leave it for others to -- thank you so much. I don't need to leave it for others. Others have dealt with that curtain.

I'll rise for the lunch break and the next witness should be here at 2 o'clock; is that right?

MS INNES: That's correct. Thank you, my Lady.

LADY SMITH: Thank you.

(1.00 pm)

(The luncheon adjournment)

(2.09 pm)

LADY SMITH: Ms Innes.

MS INNES: My Lady, the next witness is Ann Gow from Healthcare Improvement Scotland and she's the deputy chief executive there at present.

LADY SMITH: Right. Thank you.

Ann Gow (sworn)

LADY SMITH: Thank you so much for coming along this afternoon to help us with your evidence. I'm really grateful to you for doing that.

First question I have for you is: how would you like me to address you? I'm very happy to use your first name or your second name, whichever's easiest.

A. First name's fine. Thank you.

LADY SMITH: Thank you for that, Ann.

And thank you for coming along to deal with the questions we have about the written evidence we've been provided with by your organisation. As you'll appreciate, we may have questions which go beyond what's there, but could be regarded as trailed by what's there.

If at any time you have any questions or you think there are things we should be asking you that we haven't asked you, don't hesitate to speak up.

So far as timing is concerned, I normally take a break, to give everyone a breather, at about 3 o'clock. But, if you need a break at any other time, please do tell me. We can deal with that.

A. Thank you.

LADY SMITH: You have got your red folder there and that has the documentation in that I referred to a moment ago. We'll also bring it up on screen, any parts of it that we're going to ask you to think about. The screen's just that one in front of you. There's a big one behind you as well, but hopefully the small one will be enough.

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

Questions by Ms Innes

MS INNES: Good afternoon, Ann.

A. Good afternoon.

Q. We understand from your CV you are currently Deputy Chief Executive at Healthcare Improvement Scotland; is that right?
A. Yes, I am, yeah.
Q. I think we call that HIS for short?
A. Yes, yes.
Q. And we can see from your CV that you've worked with HIS since 2017; is that right?
A. Yes.
Q. And your background is in nursing?
A. Yes, yeah.
Q. And in that role, or with that background, you've held various leadership positions since December 1999?
A. Yes.
Q. I think that's when you became a nurse consultant. Then you have had various senior leadership roles --
A. Yes.
Q. -- since then?
A. Yep.
Q. And I think we can also see in your CV that you were awarded an OBE for services to nursing in Scotland at the end of last year; is that right?
A. Yes. It is, yeah.
Q. Now, if we can look, please, at the report provided by HIS, which is at HIS-000000001. It will come up on the

screen and you have a copy in your folder there.

If we can move to page 3, please, which sets the context, we can see that this report was produced following a Section 21 notice from the Inquiry. You refer to certain definitions, so a child being a person under the age of 18. Then, in respect of the definition of children in care, you say that you note that this includes healthcare establishments providing long-term care and in that regard, you are taking into account the Inquiry's advice that any hospital, treatment centre or independent healthcare service which provides overnight care has the potential to provide long-term healthcare and should, therefore, be regarded as falling within the definition?

A. Yes.

Q. So I think that's advice that you received in the context of the preparation of the answer to the Section 21 request?

A. Yes, yeah.

Q. And has that definition then been taken into account as the report's been prepared?

A. Yeah. It has been taken into account as the report's been prepared. The NHS tends not to provide long-term residential care and hasn't done since, I think, around about the 1990s. But overnight stays for children and

young people can be quite extensive, depending on their condition.

Q. So you mentioned residential care there. What distinction do you draw between the NHS providing residential care and the NHS providing overnight inpatient care?

A. So the NHS providing overnight inpatient care, the person in receipt of that, whether it be a child or young person or an adult, would be in need of healthcare, you know, rather than social care. And for children and young people, it's a loose definition because it can vary depending on who's got parental rights and responsibilities.

But, in the main, most of the children and young people who are in our care remain under the care of their own parents or the local authority, the NHS is not -- tends not to be legally responsible for them.

LADY SMITH: Sorry, Ann, you said a few moments ago, 'overnight stays for children and young people can be quite extensive'. That presents a conflicting picture in my head of one-off overnight, single night stays, but also long-term stays; can you just explain to me what you're getting at there?

A. It is. So -- and, again, we struggled with this at the beginning. So, if a child or a young person -- so, for

instance, at the moment, there are some young people in NHS care who have autism, who need to -- who have got particular housing needs and are delayed in their discharge, so their stays can become quite extensive. Or if a child is in -- I don't know, in intensive care or -- you know, a situation like that and they're not well enough to be discharged or to move to another facility, then their stays can be quite extensive. But parental responsibility sits with the parents or with the local authority, depending on legal rights.

LADY SMITH: I get that. We're not only interested in cases where parental responsibility has passed, perhaps to the state. Any case of a child being in what could properly be termed 'residential care' and that includes long-term hospital care.

A. Yeah.

LADY SMITH: Or other healthcare establishments.

A. So the differentiation we have made and we tend to use for adults in the NHS is -- so someone who's in need of NHS healthcare or, in the independent sector, someone who's in need of healthcare, rather than in need of social care.

LADY SMITH: Thank you.

MS INNES: But from what you're saying, there could be people that are in NHS care who are -- they are, in

fact, there, even although their healthcare need has been met insofar as it can be and they're actually in need of social care. And you mentioned delayed discharges from hospital, and I think we're probably familiar with that concept.

A. Yeah, yeah.

Q. So, if we can move down in your report, please, to section 1, where you talk about the history and role of Healthcare Improvement Scotland. And we can see that HIS was established in 2011 and its immediate predecessor, I think at paragraph 1.1.1, was NHS Quality Improvement Scotland?

A. Yes.

Q. And that, I think, must have been in existence from 2003 to 2011; is that right?

A. Yes.

Q. You say that it was constituted as a special health board; is that the way that HIS is constituted or not?

A. HIS is constituted as a health body, so I couldn't -- I don't have enough depth of knowledge of that to go into any detail, but it's constituted slightly differently.

Q. The NHS QIS, it says, merged five individual organisations that had been around before then, and we

can see that one of those was the Scottish Health Advisory Service.

Now, we understand from evidence that we have already heard, that this organisation seemed to visit hospitals and carry out inspections of hospitals; is that your understanding?

A. I don't have an in-depth knowledge of the Scottish Health Advisory Service, but -- and we don't -- we -- anything that we had on record, we would have shared with the Inquiry. But if there's anything else we can add later, we will.

Q. Is it an organisation that you were conscious of from your work previously?

A. Not particularly in my work previously. I'm not sure that I would have been. So, in the nineties -- you'll know from my CV that in the nineties, I was a health visitor, so I didn't deal a lot with inpatient stays.

Q. Then you list out there the various functions of NHS QIS, which included, at point 2, setting clinical and non-clinical standards of care. Then the next bullet point is:

'Reviewing and monitoring NHS services.'

And then:

'Supporting staff improving services.'

And the next point is:

'Promoting patient safety.'

A. Yes.

Q. And do you know if that organisation carried out inspections of hospitals?

A. So they carried out inspections of hospitals with particular -- so the inspection arm of QIS was particularly around healthcare acquired infection, and it was the Healthcare Environment Inspectorate, part of QIS, that carried those out. And those were carried out against a set of standards for the healthcare environment. And latterly, I think it was in 2009, following an inquiry into older people's care in, I think it was NHS Tayside, they were asked to do inspections of older people's services.

Q. So, if we go on to the next page, it tells us there, at the first paragraph, that the establishment of HIS was announced in 2008. But it didn't, in fact, come into being until 2011, as we've seen?

A. Yeah.

Q. And there you say that HIS was going to take on all the functions of NHS QIS, but it was also going to take on board the functions of the Scottish Health Council and the organisation that you have just mentioned, Healthcare Environment Inspectorate?

A. Yeah.

Q. And did the Scottish Health Council and the Healthcare Environment Inspectorate cease to exist when HIS came into being or do they still exist under the umbrella of HIS?

A. So the inspection function that was the HEI has ceased to exist as a separate function. However, we do inspections and we -- and you'll see from the evidence over time -- have changed the focus of those.

The Scottish Health Council, though, is still a constituted, separate part of HIS, with its own committee. So it continues to exist, but within HIS with a separate committee and the inspection part has been subsumed within the overall HIS body.

Q. And what's the role of the Scottish Health Council?

A. So the Scottish Health Council -- so it acts to oversee health boards in terms of the responsibility to consult patients and users on service change, and also to give advice on how best to involve the public.

Q. If we go down the page, we see, at paragraph 1.2.1, it's noted that HIS is:

'The national improvement agency for health and care in Scotland. The organisation's core purpose is to enable the people of Scotland to experience the best quality health and social care, with a specific focus on safety.'

And does that remain the core purpose of the organisation?

A. Yes, yeah.

Q. And we see reference to both health and social care there?

A. Yes. So our social care role is particularly in joint services, so in integrated services within -- in the main, within the community. And we'll work in partnership with the Care Inspectorate or, if it's in prison, with the HMIP, so with the other bodies who take the lead in those areas.

LADY SMITH: Can you give me an example of what you refer to as 'joint services'?

A. So, for example -- so there may be some joint children's services. I'm trying to think what they are off the top of my head.

So there might be a joint children's service provision for child protection, as I'm sure you've probably heard a lot about, within the community that's overseen by an integrated joint board, where you'll have health and social care staff working together, jointly, to provide support and protection for children and young people.

So we will -- we work with the Care Inspectorate lead on those inspections, for instance, and we'll work

with them to ensure that the NHS -- the health input into those is correct and meets the right standards.

LADY SMITH: Thank you.

MS INNES: And if we can look down to next paragraph, it sets out the statutory functions of HIS, which include a general duty of furthering improvement in the quality of healthcare. Then there's a duty to provide information to the public about availability and quality of services, and then, when requested by Scottish Ministers, a duty to provide advice about any specific matter.

So I suppose in terms of the reference to quality, that's where any kind of quality assurance inspection or regulatory function would come in?

A. Yes, yes.

Q. And then, at paragraph 1.2.3, it says:

'There are specific functions of the Scottish Ministers that are to be exercised by Healthcare Improvement Scotland.'

And in the first bullet point, we see:

'Supporting, ensuring and monitoring the quality of healthcare provided or secured by the health service.'

Would I be right in thinking that the health service here is not just the NHS, but also independent health services?

A. So for this function, it's primarily the NHS. We also have regulatory functions within independent healthcare services.

Q. Okay, we'll come to those separately. And then you go on to say that there are specific statutory powers, which include powers of access and right of entry for the purposes of inspection in relation to the health service, so the NHS, and also independent health services?

A. Yes.

Q. And then if we go on over the page, at the top of the page:

'The organisation has the power to direct a health board to close a ward to new admissions where there is a serious risk to the life, health or wellbeing of persons.'

So we might be familiar with that concept if there was an outbreak of infection, I suppose. Would it ever apply if there was a concern about staffing, governance, or anything -- any sort of management-type issue on a ward?

A. Yes. So we -- we've never actually had to use the power because, in essence, when -- any time the inspectors have been out and found something, like low staffing levels or staff who are inadequately trained, or

overcrowding and not enough bed spacing, then, while we're on site, the health board tends to have -- to sort the problems, so we have never had to actually close a ward.

But, no, it's around anything we would think would be an immediate risk of harm to the health and wellbeing of the people using the service.

Q. Then there is a bullet point beginning:

'Regulatory powers in relation to the independent healthcare sector ...'

And we will come on to that section of your report in due course. Then you say in the next bullet point:

'To require health boards to give such assistance to HIS as it requires, for example, to provide information in relation to its functions under the Health and Care (Scotland) (Staffing) Act 2019.'

We understand that this Act came into force in 2024. Can you explain what HIS's role is in relation to the implementation of this Act?

A. Yes, so HIS has a number of roles in relation to the implementation under the Act. So since 2012, there's been a mandate from Scottish Government to use specific staffing tools for nursing and midwifery. So HIS has a role in developing and updating those tools and making recommendations to Scottish Ministers on how they should

look and, from last year, to ensure that those tools are multi-disciplinary.

HIS also has a role in overseeing and monitoring the legislation and health boards' compliance with it. So we have a team who developed the tools, one who monitor the compliance, and we check the compliance when we're out doing inspections, just as part of the inspection as well.

Q. And we understand that health boards have to provide returns --

A. Yeah.

Q. -- on a regular basis, in respect of staffing levels, agency use and suchlike. Are those reports made to HIS or are they made directly to Scottish Government?

A. So the health boards are required to make reports directly to Scottish Government. However, if we feel, for our work in monitoring, that we need information, a return -- I mean, obviously, we've got the powers to do it, and if we're on site doing an inspection, for instance, we'll ask for things like rosters and numbers, and our team in HIS will then work that through and decide whether or not it's adequate.

Q. And are the returns made by the health boards publicised?

A. So, the returns, I'm not -- I couldn't answer for

Scottish Government returns. They tend to be laid before their boards, so they'll be -- they'll be, you know, publicly available in board papers.

Q. Okay, and I suppose one might ask: what's the underlying purpose of this legislation?

A. So the underlying purpose of the legislation is around the safety of people who use services. So ensuring that there's the right staff in numbers at the -- in the right place, at the right times, with the right qualifications and training.

Q. If we look down to paragraph 1.2.5, it says there:

'In delivering these functions there is an expectation that HIS will review and inspect the quality of healthcare in any service, both in the NHS Scotland and the independent sector, based on intelligence and evidence at a time and manner of its choosing. This applies to one-off reviews and mutually planned programmes of assurance.'

So, first of all, in relation to that, I note that it said that there's an expectation that HIS will review and inspect services. Is it just an expectation, not a requirement?

A. So there's a requirement in our legislation to make public the availability and quality of healthcare, and there's an expectation that we will do that through

inspection.

Q. And then it notes there that inspection, review and inspection, has to be based on intelligence and evidence; can you explain that, please?

A. So, I mean, as you can imagine, the NHS is vast and our team, indeed, all regulators have got, you know, limited capacity to be in every service all the time. So we -- for instance, in acute hospitals, we will ensure that we are in every acute hospital, at least every three to four years. But the priority of those acute hospitals will be based on a number of things.

So data, soft intelligence, whether people have raised issues with us directly through our -- so we're also a named body in the Public Interest Disclosure Act, so people can whistleblow anonymously to us.

Myself, in my previous role as nurse director, and our medical director and chief exec work quite hard at building relationships with other people in the service, so that we, kind of -- you know, we're learning as we go along whether there's any risks there in the sector. So that intelligence allows us to then risk rate where we're going to be led.

Q. Now, if we look down to paragraph 1.3, there's a heading there about the scope of scrutiny and assurance activity. And there, the statutory duties are referred

to again:

'There are inspections and reviews of NHS hospitals and services, and our scrutiny activity involves/covers inspection, regulation and review.'

In the next paragraph, you say:

'HIS is also the regulator of independent healthcare services.'

So just to be clear as to the division: with independent healthcare services, you are the regulator, bodies have to register with you, you can inspect them?

A. So we are -- so we are the regulator for independent healthcare services. As you say, bodies have to register with us and meet specific criteria, lead out on legislation in order to do that. And we have powers with independent healthcare services to close the service, suspend the service, and also to -- you know, to make requirements of the service around improvement. Each of those services pays us directly as a regulator to regulate the sector.

Within the public sector, we are a scrutiny body, an inspectorate and do not have the same powers. So, within the public sector, we don't have the power to apply sanctions, for instance, to health boards or to a local authority, so our powers are slightly different in each. And we work under the direction of Scottish

Ministers, on their behalf, in the NHS and public sector and our powers there are outlined above. And while we don't have the power to sanction, we will work with the sector around improvement, and we've got an operating framework, which, again, we've highlighted in the report, where we will make public, and also raise directly with Scottish Government, if we think people aren't making the improvements that are required.

LADY SMITH: Sorry, you said you will work with the sector around improvement and you've got an -- what is it you have got?

MS INNES: A scrutiny function.

A. So we've got a scrutiny and assurance function. So we provide -- we scrutinise, either through review or through inspection, and we'll provide -- so we make public, so we'll provide public assurance on the public sector services that we've got that responsibility for.

LADY SMITH: But you can't impose any sanction?

A. We can't, no.

LADY SMITH: Or even recommend any particular sanction to Scottish Ministers?

A. So we can't impose sanctions. We could recommend a particular sanction, but we don't have any legal powers to do that.

We tend to work fairly closely with -- the NHS

itself is run from Scottish Government. It's -- you know, it's run from within Scottish Government, which is different from the independent providers, and probably different from the social care providers as well.

So we will make recommendations to Scottish Government around their oversight of the individual boards. And if we feel individual boards aren't making the improvements that we would expect them to make, or if we feel there's immediate risk to public safety, our powers are limited to notifying them and for them to take further action.

LADY SMITH: Did you say something about an operating framework?

A. We do have that.

LADY SMITH: What's that?

A. So we have a framework which we've got published in our -- on our website, which outlines the actions that we'll take if we -- if we inspect a hospital or a service. And so we'll inspect a hospital or a service. We'll make requirements if we feel that they're not meeting a national standard or legislation, and we'll make recommendations if it's around good practice and quality improvement.

If we feel there's an immediate risk to life or if we feel that boards are not making the improvements that

we would expect them to make in the timescales, then we will publish a letter to the board on our website and then escalate to Scottish Ministers, who have ultimate responsibility for the service.

MS INNES: It would then be for Scottish Ministers to take action?

A. Yes.

Q. Now, at paragraph 1.3.3 on the page there, it says:

'In addition to our core programme of scrutiny activity, we may also be commissioned by Scottish Government to undertake ad hoc assurance reviews in areas of emergent and urgent need.'

And I think you do refer to this later on in your report. But we know that you've recently been commissioned, together with the Mental Welfare Commission, to undertake a review of inpatient services for adolescents?

A. Yeah.

Q. That's following on a BBC Disclosure programme about Skye House. Is that an example of an ad hoc activity?

A. So it's an example of an ad hoc inspection. So we'll do a joint inspection with -- using their inspection methodology, with the Mental Welfare Commission, using the inspection methodology as well. So we -- in terms of an inspection footprint, we do some pre-work and

we'll ask each of the boards and gather intelligence around any issues, any strengths, any weaknesses in the service. We will then go in and with -- in this case, with the Mental Welfare Commission and, in the fairly near future but on an unannounced basis, into the service, and we will have -- we will have particular focus on areas like governance, leadership, environment. The Mental Welfare Commission will have a focus on the needs of individual service users and we'll publish -- we'll analyse that, ask the board for any other post-inspection information we need and then publish a report.

We also do reviews where we might not necessarily do an inspection, but we will do a review of any available published information and we talk to individuals. And we've just published one of those on emergency departments in Glasgow and we did one on -- we were asked to do one on neonatal deaths, which we published last year.

Q. So, in terms of the work that you're doing with the Mental Welfare Commission, following upon the Disclosure programme; is there a date by which you have to report to Scottish Ministers?

A. So we will report to Scottish Ministers within 12 weeks of the date that we are on site. I can follow up with

whether or not we have agreed a final date. As I say, the inspection itself is unannounced, and we'll do them over a period of time as well.

Q. Going back to this page here, it says your plans for each programme are outlined in your annual quality assurance and regulation plan, which you agree with Scottish Government and publish on your website.

Then at the top of the next page, it is subject to any change if there was a particular area of need that you were directed to look at, like, I suppose, for example, the work that you're doing in relation to the inpatient units. I suppose that might pull resources from other areas which means that you can't do some of the work that you set out to do?

A. Yeah, so it may be that -- so even sometimes with additional resource, we need to ensure we have got the right expertise. So it might be in the case of the CAMHS inspections that we need to do some fewer -- for example, the adult mental health inspections, so that we've got inspectors who have got the right experience on those pieces of work.

Q. If we go on over the next page, you talk here about inspections and you say -- so page 6, paragraph 1.3.5.1. I think it's back a little bit.

You say:

'Inspectors undertake announced and unannounced inspections.'

If you do an announced inspection; how much notice do you give?

A. The announced inspections tend to be our joint inspections with the Care Inspectorate, where they're the lead agency. So I couldn't tell you off the top of my head what notice we give.

Our own, kind of, core methodology for inspection is unannounced and that -- I mean, the reason for that being that our inspectors should be able to walk in and experience an environment like any other member of the public or patient, or anybody who uses the services.

Q. And then if we look down to the next paragraph, 1.3.6, 'Regulation', you talk about your responsibility for registration and regulation of independent healthcare services. You say that there are five key statutory functions, amongst which are registration, inspection, and then you also mention complaints.

So in this sector; how would complaints come to HIS? Do they come directly to you?

A. Yeah, so if an individual wishes to make a complaint about a service provider in the independent sector, we will, on the whole, recommend that they make the complaint directly to the service provider. If,

however, they're not happy, then they will complain to us and we'll investigate it.

They're not covered -- those complaints aren't covered by the Scottish Public Service Ombudsman, and so the route for those is different than they would be for NHS and social care complaints.

Q. So NHS complaints, they would go through a different route? They wouldn't come to --

A. They wouldn't come to us. They'll go through -- they'll be dealt with through the individual health board or employer.

LADY SMITH: When you made reference to the Scottish Public Services Ombudsman, that means that it's those, as in the NHS complaints, they're subject to oversight of the Ombudsman and the relative board will be probably expected to follow the Ombudsman's model of handling complaints.

A. Yes.

LADY SMITH: They don't have to, but there is a recommended model there --

A. Yes.

LADY SMITH: -- as to how they should be handled.

A. So there would be an expectation and then the route for those would be, you know, for any outstanding complaints or if people are unhappy, to SPSO. But for independent

healthcare, the route is to us.

MS INNES: Then you mention enforcement, which you have already talked about.

Then you mention notifications. What's meant by 'notifications' in this context.

A. So we might give a notification to improve for both -- so that's -- that's ionising radiation services. Some of those are actually in the NHS, but are regulated slightly differently. And we would give a notice to improve whichever part of the service we think needs to improve. We have -- particularly in independent healthcare, that notice can be followed with sanctions in a way that it can't be within -- because we don't have the powers to do that within the NHS and public sector.

Q. So it's HIS making the notification, not services making notifications to HIS; no?

A. No.

Q. Okay. If we can look over the page now, you go on to look at reviews and different matters. At paragraph 1.3.7.2, you refer to responding to concerns. You say:

'HIS has a duty to respond to concerns raised by NHS Scotland staff, who wish to remain anonymous.'

That is what you referred to earlier in your

evidence, about whistleblowing essentially. So either directly to you or referred to you by someone else about the safety and quality of patient care.

So is HIS the route by which a staff member would whistleblow or not?

A. Again, it can be confusing, I think for -- I think for staff. There are two separate routes. So we're a named body under the Public Interest Disclosure Act, which I think is 1999. It's a UK Act. So people can disclose to us, and to a number of other bodies, anonymously and confidentially, if they have issues with the health and care of -- with their employers.

They can also use the NHS Scotland's whistleblowing legislation, which again -- where they can't disclose anonymously, but they do get confidentiality, so it's slightly different. And they do that through structures that are now there in the board. And the oversight body for that, it sits within Scottish Public Service Ombudsman and it's the INWO. And I cannot remember for the life of me what INWO stands for off the top of my head.

Q. So a staff member has the choice whether to go down one route or the other?

A. Yeah.

Q. Would you have any -- or are you able to give us any

sense of the number of staff that come forward?

A. There are increasing -- there are increasing numbers, so we can send you the numbers that we've got.

We'll get anywhere between, probably about -- you know, between about ten and 20, kind of, complaints coming in, either directly to us or sometimes to other bodies. So, quite often, people will disclose to a professional regulator. So the Royal College of Nursing, for instance, will get a disclosure that's not about an individual's practice, so it doesn't sit with them, but it's about, you know, systemic issues within a Scottish health board. So they'll share with us as well.

And, indeed, the recent emergency department review I spoke about earlier, that we did in Glasgow, was as a direct result of staff coming to us with issues that they were having with their employer and the board.

Q. When you mentioned between ten and 20; is that between ten and 20 a year or a month?

A. A year. A year, yeah.

Q. Then you give an example of the action taken as a result of some whistleblowing; is there a standard response or does it vary dependent on the issue raised?

A. It varies, depending on the issue raised, the context, who else might be involved. So we have -- in fact,

we're just reviewing the process at the moment. But we have a process where a number of us -- and in my previous role as nurse director, I was part of this whole reviewing issue that comes through. And we'll either signpost if we feel it's for another body or to go directly to a board, we'll deal with it directly and ask the board for an update or insight into the issue that's been raised.

Or, for instance, in the case of the ED issues in Glasgow, we'll follow through and do an inspection and a review. And we've previously done a review in Tayside for the mental health following on from issues raised through our RTC process.

Q. In the next paragraph, you refer to adverse events and you say the team works with all NHS boards to support their adherence to the national framework for learning from adverse events. And you talk about NHS boards being required to notify HIS when they commission a significant adverse event review. What sort of things are adverse events?

A. So there's a range and different categorisation depending on the severity. So the significant adverse events that are notifiable to us are usually ones that have either caused a death or have been a near miss of an individual in some sort of care.

So it might be a drug error. It could be an inpatient suicide. You know, there are a number of things that will come under that process.

So we get a notification that a board has opened one of those adverse event reviews. The board itself does the review and closes the review, and we're now working with the boards to get -- to make sure we've got, kind of, adequate and robust data to look nationally at what some of the themes might be around that, so that we can provide some improvement support.

Q. Then, in the next paragraph, you say at paragraph 1.3.7.4, you refer to the National Hub for Reviewing and Learning from the Deaths of Children and Young People, which was launched in October 2021. Does this apply to every death of a child in Scotland?

A. Yes.

Q. Irrespective of whether they're in care, at home or in a hospital?

A. Yes. And the principle of it is -- so previously a lot of deaths of children -- so if a child was in care or the death was unexpected, you know, it would have come under the SAR process. This is to make sure that we're reviewing every death of young people and, where there are gaps, we'll ensure that there's a review undertaken. And, again, as a national organisation, we're about to

publish -- we published a report last year, we're about to publish another report with thematics per age group, so, with that, if there's anything that is preventible or where you could reduce the risk, then we can make sure that, as, you know, public sector bodies, we're doing what we can.

Q. Now, if we can look on please to page 8 and section 2, where you go into a bit more depth on inspection activity, and I think this is in the NHS context.

A. Yes, yeah.

Q. So, at paragraph 2.1.1, you say that between April 2009 and December 2014, HIS carried out Healthcare Environment Inspectorate inspections, I think, and older people in acute hospitals inspections and during this period, a total of 203 inspections were carried out.

Am I right in understanding that, over that period, that was the focus of all of the inspections, which were carried out?

A. Yes, yeah.

Q. So two separate issues, Healthcare Environment Inspectorate, which is to do with infection control --

A. Yes.

Q. -- is that right? And a focus on older people in acute hospitals?

A. Yes.

Q. So none of these inspections looked at children in hospital?
A. So not directly. Both were commissioned by Scottish Ministers in response to -- so HEI in response to the Francis Inquiry, and the OPAH inspections in response to a significant event -- indeed, a number of significant events around the care of older people.

However, I mean, certainly the OPAH inspections weren't carried out in paediatric inpatients. But the HEI inspections were across all service areas, so including paediatrics and mental health.

Q. If we move on, please, to page 9, you have a heading: 'Joint inspections', and I think you've already alluded to this before. But I think, looking at the past, as it were, the inspections appear to have focused on older people's care home services?
A. During -- so the Care Inspectorate have a regulatory function in older people's care homes services. As you will no doubt be aware, there were particular issues during the COVID pandemic with infection control and cross-infection for older people. So we were asked by -- again, by Scottish Ministers, to inspect using -- because of our HEI knowledge, to inspect alongside and support the Care Inspectorate in their function in care homes for that period, which we did.

Q. Then if we go on to page 10, at the top of the page, to 2.2.2.3, you say in August 2024, you announced that you would carry out inspections of maternity units beginning in January 2025.

Am I right in understanding that that is now the focus of inspections in hospitals?

A. No, we've got a number of inspections in hospitals. So, in terms of the chronology, as we were nearing 2019, and without any foresight as to what was going to happen in 2020, we were -- we felt we had made all of the improvements we were going to make, really, doing solely OPAH and HEI inspections, and that there were perhaps other things within that inspection context that we were missing, so the systems around the frontline care that we were in to see, for example. We developed a COVID-specific inspection during the COVID period, which took into account -- so we based it on the European model for inspection, which is in the paper. But I cannot remember off the top of my head what it's called.

So we based it on that and we looked at much broader issues than just the -- you know, than just the infection and infection control; things like leadership, culture in a unit, the governance, oversight, as well as the environment and direct patient care.

These were much more observational as well, because we didn't want to interfere with busy wards where, you know, COVID was rife.

So having learned from those coming out of the COVID pandemic, we developed a safe delivery of care inspection methodology, which looks at all aspects of care within a unit, including things like oversight, culture, leadership and so on, and we make recommendations and requirements based on our findings.

Q. So we see, further down the same page, that this is an area which could potentially include children who are in hospital. You say, at paragraph 2.3.1.2.2, that the inspection footprint in each NHS board is approximately 12 weeks. So it's an unannounced inspection, with inspectors going in for -- well, inspectors might not be going into the hospital for 12 weeks, but the whole inspection itself lasts 12 weeks?

A. So what they call the footprint is 12 weeks. So the inspectors themselves will be on site anything sort of two to three days, initially. They may feel the need to go back at some point in the 12 weeks if there's something that they feel needs immediate attention. So they might go back within seven days if they feel something is unsafe, but not so unsafe that they had to close the unit, and then they'll work to analyse all of

the information they've got. If we're looking at governance and so on, they look at governance papers and evidence of things that they might have heard on the inspection, like, you know, poor culture, or the good culture, or the good working practices. Our healthcare staffing team in that time as well will look at that whether or not the unit is adequately staffed. And then we'll make -- at the end of the 12-week period, we'll publish an inspection report.

So we applied that methodology initially post-COVID within acute hospitals. We've added, since, a similar approach in mental health adult units and, in January 2025, we've added a similar approach to maternity services, and our first inspection report is to be published there either -- I think it's this week or next week.

MS INNES: Okay, thank you.

I'm going to move on to another section, so now might be an appropriate time.

LADY SMITH: Would that be a good point to break? As I said earlier, Ann, I normally break at about this time in the afternoon; is that all right if we do that now?

A. Yes, fine.

LADY SMITH: Let's do so.

(3.02 pm)

(A short break)

(3.12 pm)

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

A. Yes.

LADY SMITH: Thank you. Ms Innes.

MS INNES: Thank you, my Lady.

If I can ask you, please, to look at page 13 of the report and paragraph 2.3.4, this again is in the section dealing with NHS inspections and, there, there's a heading, 'Frequency of inspections', and then there's reference to the annual plan.

Is there a baseline in terms of which you would always go back to a particular hospital every three years, for example?

A. So we try to -- and the principle from -- I think back from the HEI days was that we will try with the major acute hospitals to get round all of them around every four years. There are a large number of acute and community hospitals and other sites. However, so, you know, given the resource that we've got, we can't get round all of them. But we try to at least get to those and then any others that are in -- you know, that are identified as being an area of risk.

Q. Then, at paragraph 2.3.5, you refer to:

'Office and qualifications of persons carrying out inspections.'

Now, there it says:

'All our inspectors are qualified professionals who are registered with governing bodies, such as the NMC or the HCPC.'

Is there any difference in the qualifications that inspectors need to have for NHS inspections, as opposed to independent healthcare services?

A. So we've got a broader range of inspectors and independent healthcare services than we've got in NHS.

So our NHS inspectors are generally nurses or allied health professionals. So they may be, you know, occupational therapists, physiotherapists, because they'll have an insight into the practice, the environment that they're in.

Within independent healthcare, historically, given the nature of some of the inspections that we're doing in some of the clinics and so on, we've also got people who are environmental health officers and have come with inspection backgrounds, rather than specifically -- you know, specifically healthcare.

However, we make sure, on those inspections, that there's an adequate mix of skill within the team, and if we feel, in either the NHS or independent healthcare

inspections, that we need to, kind of, subsidise the team with any additional expertise, so then we'll either bring someone in to give advice or bring someone in to go on the inspections.

So, if, for instance, the review we just did of ED, we brought a number of medics on board to help us with that review.

Q. If we can go on now, please, to page 14, and 2.3.7, where you're talking about conclusions, recommendations and outcomes of inspections. You say that the published methodology is that when you produce your findings, the board have to produce an initial improvement plan?

A. Yes.

Q. And then you refer to requirements and recommendations; is there a difference between requirements and recommendations?

A. There is a slight difference. So a requirement is where a nationally agreed standard has not been met or, in some cases, where legislative requirements aren't being met.

A recommendation is in order to improve quality, so where a standard's good enough, but it could be a wee bit better.

Q. So it's more to do with the subject matter of the -- of what you think could be improved, whether it's based on

legislation or not, for example, as opposed to a situation, which we might be more used to with the Care Inspectorate, where they apply a requirement and there is a consequence of that requirement not being met?

A. So a requirement, as well as being around standards, is around impact as well. So, if something's breaching the safety of people in a unit, say we went into a hospital and the bed spacing wasn't right for infection control recommendations, there would be a requirement to move those beds.

However, if the bed spacing was okay, but the area was really crowded and wasn't a great environment for patients, then we would make a recommendation. So they do vary slightly.

We do expect both to be met, though, and we will follow up both.

LADY SMITH: Ann, I understood from what you said earlier that you didn't have any powers to enforce anyone to do anything?

A. We don't. It's -- it can be difficult, and there's a bit of a debate because, you know, in other countries in the UK, so in England, for instance, the CQC is a regulator for the NHS, and we act as an inspectorate. That -- there are numerous debates about whether -- what

is the right and wrong way. But, outcomes-wise, our outcomes are not any different and sometimes better because we work --

LADY SMITH: Sorry, I just wanted to confirm with you that was what you were saying. And, of course, if you have no power of sanction, that makes sense.

A. Yeah.

LADY SMITH: Because a system would be nonsense if it conferred a power on a body, but no means by which to enforce that power.

A. Yeah.

LADY SMITH: Am I right in thinking that when you use the language of 'requirement', what you're really doing is pointing out that there is a requirement, for example, from the terms of legislation that, in your judgment, this hospital is not meeting.

A. Yes, yes, so --

LADY SMITH: Have I got it?

A. Yeah, yeah. So another sort of fairly recent example that we've seen over the last couple of years with crowded emergency departments is that their fire safety legislation isn't being met, so we've got blocked exits and things. So that would be a requirement in there that they meet that and we would be flagging the legislation, so that the boards know they need to make

those changes.

LADY SMITH: Would you intimate that to the fire service?

A. We would if we felt there wasn't --

LADY SMITH: Not that particular one, but something like that.

A. Not that particular one -- or to HSE, for instance, to the Health and Safety Executive, yeah, if we felt that there hadn't been the immediate improvement that was needed to make people safe.

LADY SMITH: Okay, because it must be right that you would be able to tell the body that did have the power of enforcement --

A. Yes.

LADY SMITH: -- that from what you'd seen, the requirements were not being met?

A. Yes, absolutely.

LADY SMITH: Right. Thank you.

MS INNES: Thank you, my Lady.

If we look at paragraph 2.3.7.3, you talk about following up on progress, so we know that there's the initial improvement plan and then you note that 18 weeks after the publication of the inspection report, an updated action plan is requested -- should that be 'from the NHS board'? To assess progress against the recommendations and requirements.

A. It should be 'from the NHS board'. The NHS -- so the NHS boards are -- each of them are independent bodies and are responsible for their own improvement. But, under our duty to monitor, we'll monitor that improvement and although it's after 18 weeks, there are various different timescales set depending on the urgency of some of the improvements that need to be made, or sometimes the practicalities of doing things, like training a whole staff group.

Q. I was going to ask that. If there was something that urgently required to be improved straightaway, presumably you would be following up on that before the 18 weeks?

A. Yes.

Q. Would you be saying: 'And this needs to be improved within a much shorter timescale'?

A. Yes. And indeed we'll have -- so, in the blocked fire exits example, which is probably quite a simple one to describe, we would go back, sometimes within days, just to check that not only what had happened when we were on site, you know, had been changed, but that change was sustained.

Q. Okay.

Yes, if we look on to page 15 and paragraph 2.3.7.8, you note there there's reference to the operating

framework above that and you say again:

'It's important to note that our powers do not extend to enforcement of any action by boards or to apply any sanctions for non-compliance.'

You may have answered this in part already. But how does that impact on compliance with requirements or recommendations?

A. On the whole, in the vast majority of cases, boards will make the improvements that we need them to make. Very often -- I mean, as you're possibly aware and have seen in the press -- very often, the act of making public the need for improvement is enough to, you know, ensure that a board makes the changes that it needs to make.

On occasion, though, although we can't apply sanctions, we will notify Scottish Government if we feel that the improvements aren't being made and haven't been made. And so Scottish Ministers appoint the executive officers and board members, and it's for Scottish Ministers then to manage that through their own direct processes with the boards.

Q. If we move on to the next section of your report where you're looking at regulation activity, so these are the independent healthcare services. You say, at paragraph 3.1.1, that prior to 2011, these were regulated by the Care Commission and when HIS was

established, that moved over to HIS?

A. Yes.

Q. And if we move on to page 16, and under section 3.3, you are talking there about, I think, current activity focused on children and young people. And you say that there are two services that you currently regulate, which are provided by children's hospices across Scotland, and you refer to those services. And you say: 'While these are not residential, they do offer care to children and young people with long-term healthcare needs, additional support needs and disabilities, or any combination of those.'

So I would understand by that -- and correct me if I'm wrong -- that those are the only services that you regulate that provide inpatient care for children?

A. Those are the ones who provide care specifically for children. There are others.

So we also regulate independent hospitals. So there are some of those independent hospitals which may, on occasion, provide services for children and young people as part of their regulation. We will check the age range they provide a service to and see whether or not we're willing to allow them to register on that basis.

Q. I suppose there might be some independent hospitals providing psychiatric care, who might also provide that

care to children on an inpatient basis?

A. Again, I'm not aware of any. But, we can -- you know, I can check with the team if there are any specifically. We do tend to put restrictions on the -- our regulatory requirements to ensure that if we don't feel that a service is able to provide the care and treatment that children and young people need, that we won't license them to do that.

Q. So one of the -- when you're registering a hospital or a healthcare setting, one of the things you could do is say that they're not permitted to care for children under the age of 18, for example?

A. Yes, yeah.

Q. If we go on over the page, at page 17, you talk about identifying relevant establishments for regulation, and that definition is set out in statute and organisations wanting to set up such a service would have to come to you and seek registration?

A. Yes.

Q. Then, if we go on over the page, to page 18, you talk about different procedures that you have relevant to this sector. At paragraph 3.3.4, you talk about frequency of inspection?

A. Yes.

Q. So in these independent healthcare settings; is there

a baseline frequency or not?
A. We do try to inspect them all. We -- there are a large number of them, so that while there are small numbers of independent hospitals, for example, there are large numbers of clinics. So, as you can imagine, we also regulate aesthetic clinics, provided by a defined group of healthcare professionals. So there are a large number of those, so we'll -- we will inspect them on registration within a time period of registration and then a re-inspection would depend on a risk assessment, which is also based on the population that they're taking.
Q. Did you say 'based on the population that they take' in terms of numbers?
A. So in terms of numbers and specific risk around that population. So we would -- a service that provides services to children, for instance. So we've got independent services that provide circumcision, for instance, to young children on religious grounds. So we would make sure that we've got some oversight of that.
Q. So the table that you have there, this is a sort of outcome of the risk assessment, as I understand it?
A. Yes.
Q. And if something is very high risk, I think it's a suggestion that there should be an inspection every

three to six months?
A. Yeah.
Q. Is that right?
A. Yes.
Q. Going down to the very low, it suggests that there would be an inspection within five years?
A. Yeah.
Q. Okay.
LADY SMITH: Who decides on the level of risk?
A. The team within the independent healthcare service use a risk rating and will decide on the level of risk.
MS INNES: How often is that reviewed?
A. I couldn't tell you off the top of my head, but I can let you know later.
LADY SMITH: And what information do they look for to enable them to accurately assess risk?
A. So they'll use -- there is a risk rating that they use that we can submit. But the areas -- so areas like whether or not there have been -- because we receive complaints about services -- so whether or not there have been complaints, whether they are high-risk procedures, what intelligence we're getting from -- because we will quite often get intelligence, kind of, across the sector. We also -- quite a lot of, particularly, the clinic services will advertise on

social media and so on, so we scan social media and things and we try to work out the level of risk there.

So there's a number of factors that we'll look at.

LADY SMITH: Thank you.

MS INNES: Then, if we go on to page 21, you talk about the conclusions, recommendations and outcomes of these inspections.

So I assume that the process is different here to that with the NHS. You publish your report; do you have recommendations and requirements again?

A. Yes. So we'll publish the report. We'll have recommendations and requirements. But we have the ability -- and we have exercised this on a few occasions -- to immediately apply for a licence to close a service or notify a service that we'll close it if it doesn't meet -- that they need to close it if it doesn't meet the requirements that we've set.

Q. And who do you make the application to, to close the service?

A. We make the application through the Sheriff Court.

LADY SMITH: When you say you'll notify the service that you'll close it; am I right in thinking you're not actually saying: 'We have the power to close you?', but you mean: 'We'll apply for a licence'?

A. Yeah, so we'll apply and we will remove their licence

and their registration.

LADY SMITH: If your application is successful?

A. Yes.

LADY SMITH: That's an application to Scottish Ministers, is it?

A. Yes. No, I think this is an application through the court, this one. So the Scottish Ministers don't oversee independent healthcare services.

LADY SMITH: Of course, we're in the independent area here. Yes.

MS INNES: I think it might be similar to Care Inspectorate powers in respect of the bodies that they regulate or the services that they regulate.

LADY SMITH: Of course.

MS INNES: If I can move on, please, to page 22, and one of the questions asked was how Healthcare Improvement Scotland hears the voice of children with disabilities or additional support needs and healthcare needs.

If I can ask you, first of all, to look at paragraph 4.2, you refer there to the incorporation of UNCRC. What difference is the incorporation of UNCRC going to make to the work that HIS undertakes?

A. So, at the moment, it's certainly strengthening our ability to engage with children and young people. So one example is -- so our own complaints process, which

does sit in the public sector complaints -- complaint model handling, we are working through how people access those -- you know, have the ability to make a complaint. And specifically working with children and young people, so that children and young people can make complaints directly to us, 'cause I don't know that we were as accessible as we should have been previously.

We are also raising awareness across the organisation. We already had child protection training, but are, you know, raising awareness of the rights of children and the need for children to engage. And we are publishing things like easy reads of our inspection reports and so on, so that they're more accessible to children and young people as well.

LADY SMITH: So have I really got the point from you that it wasn't that you didn't have the ability, the power to do it before, but the fact of the incorporation of the convention alerted you to the need to review what you were doing and see if you could do it better?

A. Yeah, so it's further raised awareness of it. And, I mean, we're always on an improvement journey, but it's helped us to improve.

MS INNES: If we go on over the page, to page 23, and paragraph 4.6, you talk about during inspections you focus on people who use the service; how do you provide

for hearing the voice of the child or the views of children who have disabilities, such that might impact on their communication?

A. So, if we're working with -- on joint inspections with the Care Inspectorate as lead agency, then the -- so, for example, you know, the Care Inspectorate will -- they have expertise and will lead on that.

In general, we -- in terms of health service engagement, we've got, kind of, specific specialist function that sits under our engagement function, which I've just forgotten what it is. Give me a second. A Scottish Health Council function.

We've got people there with specific expertise around engaging some of the harder-to-reach groups, although I think it's probably us that are hard to reach, and will work specifically to make sure that there are -- any of the adjustments that need to be made to allow us to engage with children and young people in those circumstances.

If we were specifically doing an inspection, though, that was led by us, we would ensure that we had people on the inspection team, or advising the inspection team, that would help us to make the accommodations and adjustments that we need to make, given that we are probably more used to working, you know, with an adult

population.

Q. You mentioned a moment ago about the complaints process. Obviously, people can make complaints about independent healthcare services to you, plus they might also make a complaint about HIS itself?

A. Yeah.

Q. Apologies if you've actually already covered this, but I just want to be clear about the amendments that you're making to the processes to make them more accessible for children; is that both of these issues? So both complaints about HIS and complaints to HIS about independent healthcare services?

A. Yes, yeah, both processes.

Q. And then at paragraph 4.9, on page 24, you refer to a project, Strengthening the Voices of Young People in 2017. And you say that this was a partnership with Includem, a Scottish charity that works with excluded and marginalised young people. And this was, it says, to promote the co-design of services between young people and key decision-makers. What impact did that project have in relation to HIS's services?

A. Again, I don't have in-depth knowledge of this one, only, sort of, fairly high level, so we can follow that one up.

Q. Thank you.

At paragraph 4.17, on page 25, you say:

'In February 2024, our engagement practitioners' network hosted a peer learning session delivered by NHS 24 to discuss work to establish a youth forum for young people between the ages of 16 and 26.'

Is this a youth forum for NHS 24?

A. Yes. So that's part of our working and helping boards to engage with the public. So the youth forum would be for NHS 24 to receive feedback from that specific age group.

Q. And your role or HIS's role in that is to encourage that to take place?

A. Well, to facilitate it to make sure all the recommended arrangements are in place.

Q. If we go on over the next page, please, to page 26, paragraph 4.22, you refer to the fact that you run SPSP Mental Health, which I think is the Scottish Patient Safety Programme, Mental Health.

A. Yes.

Q. You say:

'The focus for this programme has historically been adult inpatients, but we have kept an awareness of the healthcare needs of young people. This has involved attending the West of Scotland Intensive Psychiatric Care Unit planning and implementation group to share

learning and included looking at the inappropriate placement of young people in adult psychiatric care units.'

Are you able to tell us anything more about that?

A. So -- I don't have the outcomes from this specific piece of work. We do, on occasion, come across children and young people who are inappropriately placed in adult units. So not just in psychiatric care, but right across the piece and we'll make comment either in inspection reports or as part of improvement plans on what we anticipate should be the -- sometimes the training of specific staff members, if it's a very remote or rural area, where it can't be avoided, or the placement of children and young people.

We've also got a programme for adults that is focusing on reducing restraint within psychiatric inpatient units, and these are the, kind of, first steps into ensuring that that applies within CAMHS services as well.

Q. Yes. I see reference to the Reducing Restraint Network, which is looking at eradicating restrictive practices, so is HIS one of the bodies in this network?

A. So HIS, our duty to improve includes improvement teams, which, you know, includes SPSP. But we've got a broader mental health programme as well.

So as part of that broader mental health programme, we will gather the best evidence to reduce improvement, come up -- you know, have a bundle, for instance, of different interventions and work to -- across health boards and, you know, between health boards to spread some of that learning and help them with things like, you know, how they collect data to make sure they're making the improvements and other interventions that they might need.

Q. Then you go on to say:

'One of the areas of focus for the programme in the coming year is safe transitions between services, including CAMHS to adult community mental health teams, which is a known area of risk.'

So at what age would that transition happen?

A. It may vary, depending on the legal definition of the child and whatever service they're in. It tends to be between 16 and 18, but that could be a wee bit older if they're looked after and accommodated. So there are specific risks, not just with CAMHS, but any paediatric service and moving into adult services because there tends to be a much closer wrap round of services with children and young people. And when they move into adult services, quite often they'll be referred back to GPs or, you know, they have to engage with adult

services themselves, and it is a risk, particularly with children in adolescence and mental health, but across all services.

Q. Now, you go on in the next section of the report to look at HIS's responsibility for safeguarding and child protection. You note, at paragraph 5.1, that you have a duty to co-operate with local authorities when they're making enquiries to protect children. You also have a duty to take appropriate action where you are concerned that a child is at risk of harm, abuse or neglect.

So if an issue arose in the course of an inspection, which was a child protection issue or an allegation of abuse; would you refer that on to other services?

A. Yeah, we would refer it to the relevant local authority.

Q. And then, at paragraph 5.3, you talk about different levels of training that HIS staff undertake; am I right in thinking that all HIS staff have to do Level 1 Child Protection Training?

A. Yes. It's a requirement -- a requirement on -- as part of induction for new staff and also, I think, there's a two-year update required for all of our staff.

Q. And then you note that some staff undertake Level 2 Child Protection; what sort of role would those staff be in?

A. So those would be staff who are specifically working on programmes with children and young people. So, for example, the joint inspectors and some of the other inspectors who might be in areas where there are children.

Q. Then, at the bottom of page 27, you were asked to prepare an evaluation of the effectiveness of HIS in preventing and/or detecting the abuse of children in long-term healthcare in establishments which had been operational during the period.

At the top of the page, you say that you have not undertaken any formal evaluation on the effectiveness of HIS in this area. Are you able to give us any sense of how effective HIS considers that it is in preventing abuse?

A. So the thing about the formal evaluations, it's difficult to know what you've prevented. But we do put -- so there's a number of things, including our child protection training, our working with other agencies.

The thing I've not mentioned, I think, through the whole evidence is if we do have an issue with a specific board or in the joint inspections, for instance, we had -- we weren't entirely happy with the way one of the health boards was discharging its responsibilities

around child protection, then we'll take that to -- we set up a shared intelligence for health and care group, a group with other regulatory bodies across Scotland and we've now included the professional regulators.

So we'll share with them, so it's almost mirroring child protection processes, to make sure if we've only got one bit of the jigsaw, that we can act on it.

As I say, we've trained our staff. We do what we can to pick up issues of risk on any of our inspections with any of our improvement work and, indeed, provide -- as you can see from our evidence, we'll provide guidelines where necessary. So things like the standards for the -- I want to call it 'Barnahus' but it's Bairns' Hoose in Scotland provision.

However, there's always more we can do and we're aware that there's more that we can do. And, as I say, we're continuously -- so the UNCRC, for instance, brought to our awareness that we could be much better in terms of how we engage with children so we're doing that.

But there is always more, I think, that we can do to reduce the risk around children and young people being abused and -- but we are doing what we can where we can, and we're aware there are opportunities to reduce that risk.

MS INNES: Thank you, Ann. I've got no more questions for you.

LADY SMITH: Ann, can I just follow up on a practical matter?

I'm very struck at the picture that you are at the top of what's going on in relation to healthcare in Scotland, with your particular jobs to do, that I see from the lists. And your responses to us have also talked about initiatives called 'programmes', called 'groups', called 'networks', something called 'a particular approach', something which is described as an 'engagement', something described as 'a national hub', something else with -- sorry, I've lost it. Another description, 'boards' that are not your board, a different type of board.

My point is if I am not you and I'm not one of these other ongoing pieces of work, workstreams or permanent fixtures, but I want to find out what's going on -- let's say, for example, paediatrics. I need to find out everything that's being done in Scotland in relation to the delivery of paediatric care as a generality at the moment; how do I do that?

Do you keep easy access ways of doing that? Does anybody else? Or am I right in being worried about getting this sort of Sargasso Sea of wriggling eels, all

doing their own thing, but nobody really knowing which one is doing what and how you get some sort of cogency out of it?

A. So there are a number of national bodies. I'm trying to think if -- I -- and this is a personal answer, so I don't -- I don't think there is a one easy way, across Scotland, of looking at all of paediatric care. So the care delivery sits with each board. We do some oversight of the quality of care and the care delivery needs the NHS education for Scotland support with education for staff and oversight of that.

The Care Inspectorate have a role as well in providing care and protection for children and oversight of that, and local authorities have roles, as do education as partnered with local authorities. So you're right, there is a patchwork and it is -- it would be difficult to find that all in one body.

LADY SMITH: So hard to calm the sea?

A. Yeah.

LADY SMITH: Yes. Thank you.

Ann, thank you also for coming along this afternoon to answer our questions, to bring a bit more clarity to the written response we've had from you. I'm really grateful to you for doing that. I'm glad to say I can now let you go. You can escape from being trapped here

to be pummeled with questions from us. Thank you.

A. Thank you. Thank you.

(The witness withdrew)

LADY SMITH: Plans for tomorrow, Ms Innes?

MS INNES: I was just wanting to check that, because there was some discussion about moving the witness who was due to start at 11.45 to 10.00 am. So we would have one at 10.00 and a Webex at 2.00, but I don't know what the outcome of those discussions were.

If we are not starting with a live witness, we do have read-ins.

LADY SMITH: Well, so sit at 10.00 as usual and the exact order of events tomorrow will be confirmed when we start at 10 o'clock.

MS INNES: Yes, thank you, my Lady.

LADY SMITH: But it should be the same witnesses --

MS INNES: Yes, it's applicant evidence.

LADY SMITH: -- that are currently notified on the website and potentially the same read-ins.

MS INNES: Yes.

LADY SMITH: Thank you very much. Thank you. Until 10 o'clock tomorrow morning.

(3.52 pm)

(The Inquiry adjourned until 10.00 am on Thursday, 8 May 2025)

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